Physicians’ Questions and a Palliative Patient’s Answers Regarding Physical Pain: A Conversation Analytic Approach

by

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PHYSICIANS’ QUESTIONS AND A PALLIATIVE PATIENT’S ANSWERS REGARDING PHYSICAL PAIN: A CONVERSATION ANALYTIC APPROACH

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Conversation analysis (CA) was used to examine descriptions of pain, the design of questions and answers, and patterns of elaboration. I analysed audio- and video-recorded consultations involving six physicians and one patient in a supportive/palliative care clinic. The physicians enquired about a diversity of aspects of pain (e.g., severity). The patient’s answers aligned with questions indicating that his pain was stable (i.e., no change, no new pain, managed pain), which was consistent with the Clinic’s optimal health outcomes. Questions designed for a ‘no-pain’ answer were relatively infrequent. Whether or not these questions were problematic for the patient depended on when they were asked. The physicians used both single- and multi-unit questioning turns and an assortment of question types (i.e., yes/no interrogatives, yes/no declaratives, alternative questions and WH-questions). The questions were analyzed using four dimensions of question design (agenda, presuppositions, preferences and epistemic stance). While the patient accepted the topic agenda of aspects of pain, he rejected the topic agenda of pain management evaluation. He also rejected presuppositions that implied disease progression. Analysis of the action agenda showed that the physicians relied heavily on yes/no-type polar questions. Some of these encouraged elaboration (e.g., were problem
attentive); however, a number of them discouraged elaboration (e.g., were optimized or included a negative polarity item such as *any*). Some questions that discouraged elaboration allowed the physicians to progress efficiently through a checklist of standardized questions, thus aiding in the progressivity of the talk. Change-implicative talk was pervasive in the physicians’ and patient’s talk; the patient’s answers often rejected the implication that his pain was worse. The characterization of the consultations as “difficult” by some of the physicians is considered in relation to the design of questions that elicited minimal information about the patient’s pain. Study limitations (e.g., the data sample) and directions for future research (e.g., on what constitutes an optimal health outcome) are discussed, and my findings are considered in relation to palliative care practice and training. The study fills some gaps in current palliative care literature regarding the dynamics of physician-patient interactions and contributes to the CA literature on medical interactions.
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Table of Contents

Abstract.............................................................................................................................. ii
Acknowledgements.......................................................................................................... iv
Table of Contents............................................................................................................. v
List of Tables................................................................................................................... ix

Chapter 1: Introduction

Introduction....................................................................................................................... 1
Hospice Care and Palliative Care......................................................................................... 4
Physician-Patient Communication in Palliative Care......................................................... 11
CA Research in Medical Contexts..................................................................................... 27
Medical Question Design and Patient Answers........................................................... 29
Four basic dimensions of question design................................................................. 30
Agenda............................................................................................................................... 31
Presuppositions................................................................................................................. 32
Preference......................................................................................................................... 33
Epistemic stance............................................................................................................... 34
Principle of optimization and the principle of recipient design................................. 36
Principle of optimization............................................................................................... 36
Principle of recipient design......................................................................................... 37
Principle of problem attentiveness............................................................................... 38
Progressivity and cohesiveness of the talk................................................................. 39
Reasons for medical visits............................................................................................. 40
Deictics and physical gesticulations............................................................................. 41
Patterns of Elaboration in a Medical Context............................................................ 41
Cancer Care Consultations......................................................................................... 44
Using CA to Study Physician-Patient Interactions in Palliative Care........................ 48
Purpose of Dissertation and Research Questions..................................................... 51
Brief Overview of Each Chapter.................................................................................... 51

Chapter 2: Methodology

Methodology..................................................................................................................... 53
Reliability.......................................................................................................................... 55
Validity.............................................................................................................................. 56
Generalizability............................................................................................................... 57
Analytic Resources......................................................................................................... 58
Turn-taking organization............................................................................................. 58
Overall structural organization of the interaction....................................................... 59
Sequential organization............................................................................................... 59
Turn design..................................................................................................................... 59
Repair organization....................................................................................................... 60
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

Chapter 6: Discussion

Discussion ................................................................. 232
Research Questions .................................................... 232
  Existence and Aspects of Physical Pain in Questions and
  Congruence of Answers ........................................... 232
  Medical Question Design and the Patient’s Answers ........ 242
  Patterns of Elaboration and Exceptions to the
  Consistent Patterns of Elaboration ......................... 253
  Additional Findings: Troubles Resistance ................. 256
“Difficult Consultations” ........................................... 258
Comparison of Findings with Other CA Medical Research ... 262
Limitations ............................................................. 267
Implications for Palliative Care Practice and Training ........................................ 270
Future Research ........................................................................................................ 274
Conclusion .................................................................................................................. 275
Postscript ................................................................................................................... 276
References ................................................................................................................... 278

Appendices ................................................................................................................. 298
Appendix A: Glossary .................................................................................................... 298
Appendix B: Communication Criteria for Palliative Rotation ................................. 304
Appendix C: Edmonton Symptom Assessment Survey (ESAS) .............................. 305
Appendix D: 28 Sequences of Pain Talk ..................................................................... 310
Appendix E: Transcription Notation ......................................................................... 341
List of Tables

Table 1. Existence of Pain................................................................. 78
Table 2. Non-Specific Questions About Pain.................................. 79
Table 3. Specific Aspects of Pain.................................................. 80
Table 4. Single-Unit Questioning Turns and Answers/Responses...... 99
Table 5. Multi-Unit Questioning Turns and Answers....................... 169
Table 6. Structural Analysis of Physicians’ Multi-Unit Questioning Turns........ 187
Chapter 1: Introduction

The goal of hospice care and palliative care is to treat each patient as a unique individual and a whole person (holistic care) (Billings, 2000; Cannaerts, de Casterlé, & Grypdonck, 2004; Ragan, Wittenberg-Lyles, Goldsmith, & Sanchez-Reilly, 2008; Twycross, 2002; Vickridge, 1998). Healthcare providers in hospice and palliative care work to relieve the physical, psychological, social, cultural and spiritual concerns and suffering of persons with life-limiting illness, and they assist patients to maintain an acceptable quality of life (Twycross, 2002).

The delivery of hospice and palliative care services is facilitated through effective communication (Ragan et al., 2008). One of the key elements of physician-patient communication in any type of medical consultation (e.g., palliative care, acute care, primary care) is the solicitation of information from patients about their medical history and their immediate concerns (Boyd & Heritage, 2006; Heritage, 2010; Robinson, 2006; Stivers & Heritage, 2001). The type and amount of information physicians obtain has a direct impact on the kind of care patients receive. That is, if a physician obtains only minimal information about a patient’s medical history and presenting concerns, it is likely that the physician will not produce a comprehensive or effective patient care plan. The quality and amount of information physicians obtain during consultations is closely related to their ability to question patients (Heritage, 2010; Lussier & Richard, 2004). According to Heritage (2010), “few medical visits pass without a significant number of physician questions” (p. 42), and the majority of the questions are aimed at learning about the patient’s presenting concerns and medical history. Researchers examining physicians’ questioning have found that between 60% and 80% of the information physicians need to
arrive at a diagnosis and to develop a treatment plan is obtained from questioning patients (Lussier & Richard, 2004). Physicians’ questions relevant to patients’ reasons for medical visits and medical history are thus a “critically important dimension of medical care for accurate diagnosis and appropriate treatment” (Heritage, 2010, p. 42).

Ensuring that patients with life-limiting illness receive appropriate pain management is a primary concern for palliative care physicians (Warren, 2010; Wilson et al., 2009). Research in this area has found that palliative patients report pain as their most prevalent symptom (Peters & Sellick, 2006; Potter, Hami, Bryan, & Quigley, 2003). As well, patients stress the need for more discussion about pain management with physicians (Chochinov, 2002; de Jong & Clarke, 2009). According to Perron and Schonwetter (2001), palliative care “pain management must be responsive to the patient’s changing symptoms” (p. 4); therefore, assessing changes such as the occurrence of new pains (in general or in specific areas of the body) or an increase or decrease in severity of pain allows a physician to map the progression of (or lack thereof) a patient’s disease. That is, monitoring changes in pain allows the physician to determine if: (a) the patient’s condition is stable; improving or deteriorating; and (b) if the current pain management plan is appropriate or if it needs to be altered (Barnard & Gwyther, 2006). Verbally assessing the status of a patient’s experience of pain requires two sequentially related elements: (1) a set of physician’s questions that inform his or her diagnostic assessment

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1 The International Association for the Study of Pain (2012) defines pain as “a sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (http://www.iasp-pain.org/Content/NavigationMenu/GeneralResourceLinks/PainDefinitions/default.htm#Pain).

2 In a medical context, the term “stable” refers to symptoms that are unchanged or that have not declined significantly over a period of time (MediLexicon International, 2012).
of the patient’s pain; and (2) a set of patient’s answers that disclose various features of his or her pain (e.g., existence of pain, site severity, quality) (Heath, 1989).

Adequate control of physical pain has been empirically linked with various aspects of quality of life for people with life-limiting illness (e.g., increased activity, decreased depression, and a reduction in the perceived severity of other symptoms; Meuser, Pietruck, Radbruch, Stute, Lehmann, & Grond, 2001). However, research has found that even with an emphasis on pain management, approximately 30% of palliative care patients continued to tolerate physical pain that causes significant discomfort and sometimes disability (Meuser et al., 2001).

There is a good deal of quantitative research on palliative care patients’ experiences of physical pain (e.g., Peters & Sellick, 2006; Potter et al., 2003; Ventafridda, De Conno, Ripamonti, Gamba, & Tamburini, 1990) and a small body of qualitative research (e.g., Boström, Sandh, Lundburg, & Fridlund, 2004; Chochinov, 2002; de Jong & Clarke, 2009). The findings from this body of research accentuate the importance of physicians’ assessments of physical pain. However, the research does not examine the finer details of physicians’ and palliative patients’ talk about patients’ experiences of physical pain, specifically, physicians’ use of questions to assess patients’ pain and their relationship to patients’ answers.

Conversation analysis (CA) has been used to analyze patients’ naturally occurring talk about their experiences of physical pain during physician-patient consultations (e.g., Beach, 2009; Gill & Maynard, 2006; Halkowski, 2006). This form of qualitative analysis provides a detailed description of the means by which patients disclose their experiences of physical pain to physicians (e.g., through elaborated or expanded answers to
physicians’ questions). However, this work does not address pain disclosure by patients in palliative care. The purpose of the present study is to examine the ways in which physicians in a supportive/palliative care clinic and a palliative patient negotiate an understanding of the patient’s experiences of physical pain through questions and answers.

The remainder of this chapter will provide: (1) definitions and a brief history of hospice and palliative care; (2) a review of the literature on physician-patient communication in palliative care and a discussion of its limitations; (3) a review of conversation analytic research in medical contexts as it pertains to the main areas of analysis in this study; (4) a discussion of the value of using conversation analysis to study physician-patient interactions in palliative care; (5) a statement of the research questions; and (6) an overview of the remaining chapters.

**Hospice Care and Palliative Care**

The terms *hospice care* and *palliative care* are often used interchangeably. Although they are related concepts, they are distinguishable. The word *hospice* comes from the Latin word *hospis* meaning host and guest (Ragan et al., 2008; Simms, 2007). It is the root word of other words such as hospital, hospitality and hostel (Simms, 2007). The term hospice originated in the Middle Ages to describe safe houses where people who were injured, ailing, in pain or weary could stay to find safety, rest, refuge, peace and heal (Doyle, 2003).

Cicely Saunders founded the first hospice, St. Christopher’s, in London, England in 1967 (Doyle, 2003; Saunders, 2001). She believed that patients and their families needed to be provided with an alternative to the “medicalization of death and dying”
(Vickridge, 1998, p. 64); they needed care that focused on the premise of holistic comfort rather than taking a curative approach (Saunders, 2001; Vickridge, 1998). She stressed the need to assist patients and their families to experience optimal quality of life, value of life and meaning of life during the dying process (Doyle, 2003; Saunders, 2001; Smith, 2008; Twycross, 2002; Vickridge, 1998). According to Saunders (2001), the preferences, needs, goals and concerns of the patient and his or her family should guide the type of care each patient receives. One of the concerns that she addressed was pain; she coined the term “total pain” (Saunders, 2001, p. 799) to describe the complexity of pain for palliative patients (Barnard & Gwyther, 2006; Saunders, 2001). Total pain comprises the “whole experience of profound suffering, often endured at the end of life” (Saunders, 2001, p. 799). That is, it encompasses a complex array of features that embody experiences of physical pain (e.g., severity, site, quality) as well as “emotional, social, bureaucratic, financial and spiritual” elements (Saunders, 1967, as cited in Barnard & Gwyther, 2006, p. 30).

Saunders organized in-home hospice care in London communities in 1969 because there was a demand for services for the patients who wished to live out the remainder of their life in their home with their families (Doyle, 2003; Saunders, 2001; Smith, 2008; Twycross, 2002; Vickridge, 1998). Developing a relationship among the hospice service providers, the patient, the family, and the community was essential to ensuring optimal care for dying individuals. According to Saunders, good communication practices between patients, family members and hospice providers are paramount to providing good quality hospice services.
Saunders exported the hospice concept to the United States in 1971 by sending a team of trained physicians to New Haven, Connecticut (Saunders, 2001; Twycross, 2002). This became the first modern hospice facility in the United States. Hospices soon spread to the “white commonwealth countries” (Twycross, 2002, p. 271). As the hospice movement developed, the term hospice became synonymous with end-of-life care and hospices came to be seen by the public as stark and frightening places. The term hospice was replaced with supportive care in 1982 (Ragan et al., 2008), but later in the mid-1980s supportive care was replaced with palliative care by the Association for Palliative Medicine of Great Britain and Ireland (APMGBI) (Twycross, 2002). By 1987, palliative medicine became a specialty in the United Kingdom, North America, Australia, New Zealand, Hong Kong and Sweden (Doyle, 2003; Twycross, 2002).

In the modern sense, hospice care refers to the overall support and care of persons with a life-limiting illness who are at the end of life (Ragan et al, 2008). Modern hospice care is synonymous with end-of-life care but is distinct from modern palliative care: hospice care is one aspect of palliative care. That is, palliative care offers a broader range of services to patients with serious, advanced illness during the entire course of their illness, with hospice care being provided near the end of terminally ill patients’ lives.

Palliative care is often referred to as comfort care because it largely focuses on the management of specific symptoms (e.g., pain, nausea, constipation) and the services are provided to patients for the duration of their life-limiting illness (Ragan et al, 2008). The term palliative is derived from the Latin word pallium, meaning cloak (Ragan et al., 2008; Simms, 2007; Twycross, 2002). Palliative care is defined as care that cloaks

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3 The term supportive care is still used today by some outpatient clinics that provide palliative care services.
symptoms, surrounds patients with caring, and provides comfort to patients with a life-limiting illness. This is in contrast to non-palliative care, which pursues curative measures, often times at the expense of the patient’s quality of life.

Palliative care is both a philosophy of care and a well-organized and structured system for providing care (Faull, 1998; National Consensus Project for Quality Palliative Care [NCPQPC], 2004). The guiding philosophy of palliative care is to provide comfort and care to individuals with life-limiting illness, while simultaneously providing them with opportunities to partake in autonomous decision-making and to gain as much enjoyment as possible from their life (Cannaerts et al., 2004; Twycross, 2002; Vickridge 1998). This philosophy reflects Saunders’ original concept of hospice care because it is a concern for the quality of life, the value of life and the meaning of life (Doyle, 2003).

These three concepts are abstract and are difficult to define operationally because they are highly subjective. However, general definitions are provided in the palliative care literature. Quality of life, as defined by terminally ill patients, “encompasses freedom from suffering, respect for dignity and autonomy, and the freedom we all need to be ourselves” (Doyle, 2003, p. 362). Value of life entails the recognition that although the patient may physically be unable to be a productive member of society, he or she still has value as a human being (Cannaerts et al., 2004; Doyle, 2003; Twycross, 2002; Vickridge, 1998). One of the important tasks for palliative care professionals is to show patients that they are valuable, that they matter. Meaning of life reflects the goals of “remembering, reassessing, reconciling and reuniting—all goals that are translatable cross-culturally” (Jones, 2005, p. 440-441).

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4 The concept of palliative care is evolving and some palliative care providers combine comfort and curative care as a means of providing patients with the best possible care (see Meyers & Linder, 2003).
Palliative care as a system of care is the provision of diverse services provided by experienced, multi-disciplinary specialist palliative care service teams that have a breadth of expertise (Faull, 1998). The teams most commonly consist of a physician, nurse, social worker, pharmacist and spiritual counsellor (Billings, 2000; Cannaerts et al., 2004; Faull, 1998; NCPQPC, 2004). The teams may include other professionals such as nursing assistants, home care attendants, dieticians, case managers, occupational therapists, physiotherapists and trained volunteers. Good quality communication between the team members, between patients and palliative care service professionals, and between family members and palliative care service professionals is key to ensuring continuity of care during patients’ changing needs and transitions across care settings (e.g., home care, hospital wards and emergency units, extended care and assisted living facilities, and outpatient environments such as supportive/palliative care clinics). Ideally, the palliative care system is dedicated to providing equitable care “across all ages and patient populations, all diagnostic categories, all healthcare settings including rural communities, and regardless of race, ethnicity, sexual preference, or ability to pay” (NCPQPC, 2004, p. 614).

Palliative care stresses the importance of providing patients with care that includes assessment, diagnosis, physician-patient shared care planning, symptom management, monitoring, and follow-up, and that neither hastens nor postpones death (Billings, 2000; Cannaerts et al., 2004; Twycross, 2002; Vickridge, 1998). Within palliative care services a space is created for patients and their families that affirms life and diverts attention away from the sick body. Using creative and active care, palliative care continually seeks to assist the patient with finding meaningful ways to spend the
remainder of his or her life. According to Cannaerts et al. (2004), “Life is raised above illness, and the dying process can be experienced as an inherent aspect of life” (Cannaerts et al., 2004, p. 821); “In this way, patients do not feel they have been parked in the waiting room of death” (Cannaerts et al., 2004, p. 831). The main differences between specialised palliative care and non-specialised end-of-life care (provided by general practitioners in acute or intensive care units in hospitals or extended care facilities) is that specialised palliative care maximises the experience of life while dying and non-specialised end-of-life care simply provides comfort care that gives minimal consideration to the patient’s quality of life.

Palliative care is not focused only on the patient. The philosophy and system of care extends to the patient’s family by providing a support system to assist family members to cope with the patient’s illness and through the bereavement period (Billings, 2000; Cannaerts et al., 2004; NCPQPC, 2004). The support system ensures that care information and options are provided to the patient and family on an ongoing basis and in an easily understandable manner. The support system is considered to be essential in assisting family members to cope with their loved one’s illness and inevitable death.

Currently, the Association for Palliative Medicine of Great Britain and Ireland has over 1000 members in approximately 110 countries, providing more than 8000 hospice/palliative care services worldwide (APMGBI, 2010). However, approximately 49% of the countries in the world do not offer any form of hospice/palliative care services (APMGBI, 2010; Twycross, 2002). Further, the majority of modern hospice/palliative care services are provided in “predominantly affluent, privileged,
developed countries of the West” (Doyle, 2003, p. 149; see also APMGBI, 2010; Twycross, 2002).

In Canada, research has found that 90% of Canadians with life-limiting illness can benefit from skilled or specialised palliative care services, yet only 16 to 30 percent\(^5\) of all Canadians with life-limiting illness have access to these services (Canadian Hospice Palliative Care Association [CHPCA], 2010). Much of Canada’s palliative and end-of-life care is provided by family physicians who have limited training in pain management and in the communication skills appropriate for caring for people with advanced, life-limiting illness (CHPCA, 2010). For example, physicians must know how to: (a) break bad news to patients; (b) actively listen to patients’ concerns about the dying process and death; (c) adequately address patients’ concerns; (d) encourage patients to continue talking and disclose more detailed information about how they are experiencing their illness; (e) assist patients to express their feelings and concerns about their illness; and (f) show patients that physicians understand the patients’ point of view and are empathetic to their situation. It has only been in the last decade that Canadian medical schools have implemented some specialised communication training specific to palliative care situations in their regular curriculum (CHPCA, 2010).

Currently in Canada, seniors make up the fastest-growing age group that is in need of specialised palliative care services (CHPCA, 2010). It is estimated that by the year 2041 one in four Canadians will be 65 years or older. It is also estimated that the majority of these seniors will be suffering from some form of chronic illness (e.g., diseases of the circulatory system and/or respiratory system), and many will be suffering from some form of cancer. Many people with life-limiting illness die in pain, with little

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\(^5\) This statistic depends on where people live in Canada (e.g., rural or urban communities).
knowledge of their prognosis and care options, and with many unmet physical, psychological, social, cultural and spiritual needs (Billings, 2000; Doyle, 2003; Heyland et al., 2010; SUPPORT, 1995). Further, they are often receiving very costly and inappropriate medical care.

In 2002, the World Health Organization (WHO, 2012) adopted the following definition of palliative care: “Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” On its website, WHO lists pain management as the first duty of palliative care. WHO also stresses that a key element of pain management is the assessment of pain by means of medical questioning, physical examination and diagnostic testing. Even though many medical professionals in North America strive to provide quality end-of-life care to their patients, an emphasis on curative rather than comfort care, a lack of formal training in providing palliative care and communicating effectively with patients, inadequate attention to pain assessment and treatment, and an unwillingness of practitioners to accept the inevitability of death often result in patients experiencing considerable unnecessary suffering in their final months and days of life (Billings, 2000; Doyle, 2003; Heyland et al., 2010; SUPPORT, 1995).

**Physician – Patient Communication in Palliative Care**

There is a general consensus among researchers and palliative care providers that consistent, good physician-patient communication is one of the critical elements in

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6 This definition is found on the World Health Organization’s website: http://www.who.int/cancer/palliative/definition/en/
providing high-quality patient care in palliative care environments (e.g., Aldridge & Barton, 2007; Arnold, 2003; Bradley & Brasel, 2008; CHPCA, 2010; Desharnais, Carter, Hennessy, Kurent, & Carter, 2007; Friedrichsen & Milberg, 2006; Wilkinson, 2003/2011). Research has found that many patients and family members, even years after the interaction, can provide very detailed accounts of events such as receiving bad news and these encounters have the potential to influence subsequent healthcare interactions and patients’ quality of life and end-of-life care (Cooley, 2005; Fallowfield & Jenkins, 2004). Therefore, possessing effective communication skills is essential for physicians who provide care to patients with life-limiting illness (Bradley & Brasel, 2008).

The physician-patient palliative or end-of-life relationship is “undoubtedly one of the most difficult among interpersonal relations for it involves interaction between individuals in non-equal positions, is non-symmetrical and non-voluntary, concerns issues of vital importance, is emotionally laden, and often requires close cooperation” (Chaitchik, Kreitler, Shaked, Schwartz, & Rosin, 1992, p. 41). It is not surprising that studies have found that communication between doctors and patients during palliative and end-of-life interactions is often poor (Aldridge & Barton, 2007; Back, Arnold, Baile, Tulsky, & Fryer-Edwards, 2005; Heyland et al., 2010; Wilkinson, 2003/2011). Quantitative research conducted in Canada reports that palliative patients and families consider the highest-priority areas of palliative care (specifically end-of-life care) in need of improvement to be: (a) assessment and treatment of emotional problems, (b) physician availability, and (c) physician communication (e.g., talk without jargon; being talked to in a manner that demonstrates consideration, compassion, support and that helps to preserve
the patient’s sense of dignity; physician attentiveness and demonstration of active listening) (Heyland et al., 2010).

Research conducted in the United States with patients receiving specialized palliative care services reports a significant increase in patients’ quality of life and patient and family satisfaction with care when they have good communication with physicians and other healthcare professionals (Billings, 2000). In contrast, poor palliative and end-of-life physician-patient communication can seriously impact the quality of a patient’s care and of their end-of-life experience (Arora, 2003; Back et al., 2005; Bakker, Fitch, Gray, Reed & Bennett, 2001; Chan & Woodruff, 1997; Cooley, 2005; Cordella, 2004; Desharnais et al., 2007; Schapira, 2004; Thorne, Bultz, Baile, & The SCRN Communication Team, 2005). For instance, deficiencies in physician-patient communication can increase the physical, psychological, emotional, and existential suffering of patients and their families (Back et al., 2005; Thorne et al., 2005). Specifically, ineffective end-of-life physician-patient communication has been empirically linked with:

a. an increase in misunderstandings (Bakker et al., 2001; Cordella, 2004; Fallowfield & Jenkins, 1999);

b. a reduction in patients’ disclosure of symptoms and concerns (e.g., brief answers without elaboration) that contributes to poor symptom and pain control (Back et al., 2005; Fallowfield & Jenkins, 1999);

c. a detrimental impact on the quality of patients’ end-of-life decision-making (e.g., not being told the truth about their prognosis and/or not being informed about possible options for hospice palliative care services.
or place of death that results in patients not having adequate time to prepare for death) (Back et al., 2005; Bakker et al., 2001; Fallowfield & Jenkins, 1999; Fallowfield, Jenkins & Beveridge, 2002);

d. an increase in the utilization of healthcare resources by patients as a result of emotional and psychosocial distress (e.g., increased anxiety and depression, ineffective coping, hopelessness, reduced quality of life) (Back et al., 2005; Bakker et al., 2001; Desharnais et al., 2007; Schapira, 2004; Thorne et al., 2005); and

e. heightened anger toward the physician that can lead to dissatisfaction with services and possible litigation. (Barclay, Blackhall & Tulsky, 2007; Bakker et al., 2001; Chan & Woodruff, 1997; Fallowfield & Jenkins, 2004; Ptacek & Ptacek, 2001; Thorne et al., 2005)

Taking the time and making the effort needed to collaboratively build a good physician-patient working relationship not only benefits patients’ psychological and emotional well-being at end-of-life, but also benefits physicians (Schapira, 2004). Research has found that physicians without adequate training in giving bad news to patients reported experiencing feelings of inadequacy, sorrow, guilt and failure when talking with patients with life-limiting illness (Fallowfield & Jenkins, 2004). As well, discussing end-of-life issues with patients can remind physicians of their mortality and possible fear of death. These discussions have been linked with increased stress and risk of physician burnout (Cooley, 2005; Fallowfield & Jenkins, 2004). In contrast, physicians who reported consistently working to improve the quality of their communication practices with their terminally ill patients experienced increased career satisfaction,
decreased risk of burnout, less stress regarding possible threats of litigation (Bradley & Brasel, 2008; Schapira, 2004), and a better understanding of their feelings about their own mortality (Cooley, 2005).

Although this body of quantitative research provides some insight into communication practices in palliative and end-of-life care settings, it does little to elucidate the interactional dynamics of physician-patient palliative and end-of-life consultations. These retrospective quantitative studies (e.g., Chaitchik et al., 1992; Chan & Woodruff, 1997; Desharnais et al., 2007; Detmar, Muller, Wever, Schornagel, & Aaronson, 2001; Heyland et al., 2005; Ptacek & Ptacek, 2001) use questionnaires asking patients to quantitatively evaluate their physicians’ communication skills (e.g., assessment of physical pain symptoms, talk without medical jargon, demonstrations of active listening), rather than naturally occurring data to capture actual communicative practices. Further, these studies elucidate little about the finer details of the ways in which physicians and patients negotiate physical and psychosocial information during palliative care consultations (Bakker et al., 2001; Cegala, 1997; Fallowfield & Jenkins, 1999).

There is little empirical qualitative research that might address the lack of detail regarding physician-patient communication practices in palliative care settings. The small body of research that does exist utilizes various qualitative techniques. For example, the observational content analysis study conducted by Dean and Major (2008) focused on the use and purpose of humour in an inpatient palliative care unit (nature of patients’ life limiting illness undisclosed). They found that humour was important in facilitating co-operation, alleviating tension, and developing “emotional flexibility (that can) ‘humanise’
the healthcare experience” (Dean & Major, 2008, p. 1088) for both healthcare providers and patients.

A content analysis study by Ford, Fallowfield, and Lewis (1996) focused on the structure and content of bad news delivery in physician-patient consultations. This study used the Roter Interaction Analysis System to analyse 117 audio-taped physician-patient cancer consultations. The authors: (a) tallied the ratio of the use of open-ended to closed-ended questions by physicians; (b) calculated the ratio of biomedical talk to psychosocial talk; (c) ascertained the number of opportunities patients were given to ask questions; and (d) determined how many questions patients asked. The authors found that only the physicians used closed-ended questions and they used them to inquire about both biomedical and psychosocial issues significantly more frequently than open-ended questions (in a ratio of 4:1). The discussions focused mainly on biomedical information, with little time spent discussing psychosocial issues. Finally, patients were given few opportunities during consultations to initiate discussion or ask questions. The researchers concluded that the patients in this study were well informed about their diagnosis, prognosis and care options, but that physicians probed little into the psychological, emotional and social well-being of the patients (Ford et al., 1996).

Yedidia’s (2007) grounded theory study focused on the use of a patient-centred approach to physician-patient communication in end-of-life situations. He observed 40 patients with varying diagnoses receiving care from an inpatient hospice service, interviewed the patients and their families, and interviewed hospice physicians and nurses to determine the level of patient-centred care in physician-patient interactions. It was

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Footnote: Ford et al. (1996) claim their study is qualitative. However, they use qualitative data to produce primarily quantitative results.
determined that five main tenets comprise good quality patient-centred care in hospice environments. First, it is important that communication with a patient address a range of the patient’s needs (e.g., physical, psychological, social, emotional, existential). For such communication to be effective, it must be enacted by all members of the healthcare team attending to the patient. Second, palliative care providers need to be skilled listeners and communicators and be willing to explore the patient’s world as a means of ensuring that the patient’s values, beliefs, and preferences are considered. Further, the physician must recognize that while each member of the healthcare team is an authority in his/her field, the patient is an authority on the experiences occurring in his/her mind and body. Third, the physician must work to develop and maintain trust with the patient during the transition from curative to comfort care and throughout comfort care. Fourth, emotional involvement by the physician is important. Patients stated that appropriate emotional displays (i.e., demonstrations of empathy and/or sympathy) by physicians facilitated trust and relationship building, which helped patients to feel more comfortable about allowing physicians into their lifeworld. Finally, the physician must be authentic in his or her interactions with the patient. This was considered to be the cornerstone of patient-centred care. Patients valued physicians who treated them as individuals instead of types or diseases, who guided patients in the process of shared decision-making, and who were willing to be emotionally vulnerable rather than following a socially prescribed role of a disengaged healthcare provider (Yedidia, 2007).

Aldridge and Barton (2007) used discourse analysis to study communication strategies that allow for the transition from curative to palliative care. They audio-recorded 20 end-of-life discussions between physicians and terminally ill patients (with
Barton, Aldridge, Trimble, and Vidovic (2005) conducted an exploratory discourse analytic study that examined end-of-life discussions in a surgical intensive care unit (SICU) involving six patients with life-limiting illness (suffering from varying illnesses: cancer, heart disease, kidney failure, and severe infections of the abdominal, intestines and blood), their family, their attending physician and other SICU staff. The researchers found that these discussions contained up to four phases. The authors argue that the function of the opening phase (Phase 1) is to cast the interactants into traditional roles, with the physician cast as the interactional lead and the patient cast in a passive position. The description of the patient’s current status (Phase 2) allows the physician to establish the patient as terminal. The holistic decision-making phase (Phase 3) works to achieve a consensual decision from the group that the patient’s life support should be withdrawn. Phase 4, discussion of the logistics of dying, allows the physician to elaborate on the process the patient will experience while dying (in a combination of medical and lay terms). The authors argue that Phase 2 is crucial, as without it the discourse does not
progress to the final two phases. That is, if the physician is unable to convince the patient and her/his family that the patient’s condition is terminal, the progression of the discussion will be stalled and the patient will not be afforded the opportunity to decide to move from curative to comfort care (Barton et al., 2005).

Rogers and Todd (2000) used content analysis “guided by conversational analysis of institutional talk” (Rogers & Todd, 2000, p. 301) to study the process of communication between oncologists and cancer patients in outpatient cancer clinics. The specific focus of this research was to examine the talk pertaining to patients’ experiences of physical pain. The researchers audio-recorded a total of 74 physician-patient consultations (participant sample = 43 female patients, 31 male patients, 15 physicians and 7 nurses). It was found that the physicians designed their questions about the patients’ pain and guided the conversations to limit the discussions to the “right kind of pain” (Rogers & Todd, 2000, p. 303), that is, pain that can be effectively managed via cancer treatments such as radiation and chemotherapy. The physicians employed an “information-limiting strategy” (Rogers & Todd, 2000, p. 303) to obtain pain information from the patients as a means of determining if the patients’ pain was the right kind. Specifically, the physicians (a) interrupted patients when the topic shifted from the physicians’ agenda; (b) minimized, dismissed and/or ignored patients’ talk about symptoms not relevant to the right kind of pain (i.e., discouraged elaboration); (c) changed the topic back to the physicians’ agenda during deviations; (d) limited their talk to objective clinical information; (e) gave patients premature reassurance about their condition as a means of closing off the patients’ topic to move forward with the

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8 Rogers and Todd’s (2000) study is primarily a content analysis with only traces of conversation analysis (CA). That is, their analysis does not contain the fine-grained sequential analysis associated with CA research; rather, they use a few CA concepts to enhance their content analysis.
physicians’ agenda; and (f) limited patients’ responses by using questions designed to favour simple yes- or no-type answers or by asking questions that favoured answers that indicated optimal outcomes and discouraged elaboration. The authors argue that the physicians’ focus on obtaining information relevant only to a specific type of pain defined their roles within the narrow parameters of providing specialist cancer pain relief services and not as symptom management providers. As well, the authors speculate that the physicians’ inadequate exploration of the full scope of patients’ experiences of pain “is likely to be detrimental to symptom control” (Rogers & Todd, 2000, p. 305).

Rogers and Todd (2010) report that they used conversation analysis to analyze the pain talk of 74 patients with 15 physicians during oncology outpatient consultations. They found that in the cases in which the physician or the patient’s companion initiated talk about the patient’s pain, the patient frequently responded to the physician’s questions with discursive tactics that minimized his/her experience of pain (i.e., denial of pain; minimizing language such as “a little slight ache that is all” [Rogers & Todd, 2010, p. 277]; responding with hesitation such as “it’s feeling a bit a bit sore” [Rogers & Todd, 2010, p. 277]; attributing their experience of pain to noncancerous causes). The authors speculate that these patients minimized their experience of pain to conceal disease progression or a possible recurrence of the cancer. In contrast, two patients (out of the 74) initiated pain talk and were more assertive about expressing their experiences of

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9 Rogers and Todd’s (2010) analysis of this phenomenon does not demonstrate the fine-grained analysis that is consistent with CA research. That is, they do not consider Jefferson’s (1988) CA research on troubles-resistance talk (i.e., speakers display troubles resistance by minimizing troubles telling when discussing distressing events in everyday conversations). Nor do they consider the CA research conducted by Gill and Maynard (2006), Heritage and Maynard (2006) and Heritage and Robinson (2006a) that examines troubles-resistance in patients’ talk during medical encounters (see Chapter 2 for details about these studies). Inclusion of these resources in the analysis would have assisted Rogers and Todd (2010) in developing a deeper understanding of what the patients in their research were doing with their talk.
physical pain. That is, they (a) used language that emphasized their pain (e.g., “horrible pain”; “I have never felt as bad as this in my entire life”; Rogers & Todd, 2010, p. 272); (b) expressed concern about their situation via elaborated answers (e.g., “I do worry about you know what it is sometimes”; Rogers & Todd, 2010, p. 272); (c) used technical medical language in their elaborated answers (e.g., “I am on repeat sinus inhalations which keeps them [the sinuses] clear. But um they both feel achy and that one I always suspected, that’s the one I had the tumour on”; Rogers & Todd, 2010, p. 273); (d) “recycled” (Rogers & Todd, 2010, p. 271), or reintroduced the talk of pain later in the consultation as a means of displaying dissatisfaction with the physicians’ earlier resolution of the topic; and (e) interrupted the physicians’ turn at talk to change the topic and provide elaboration about their experiences of pain. In both of these cases the patient declined further curative treatments and requested a referral to a palliative care pain specialist.

Finally, Öhlén, Elofsson, Hydén, and Friberg (2008) contend that they used conversation analysis (CA) to examine the communication patterns of physicians and patients during oncological palliative care consultations. However, their analysis falls short of the type of fine-grained analysis that is associated with CA research. Instead, the authors focused on the number of turns, the number of words per turn, the duration of turns, the topics discussed, the initiation of those topics and the conversational framing of topics (i.e., as either medically oriented or personally oriented toward the patient) during video-taped consultations. It was found that the conversational space of the consultations was dominated and controlled by the physicians. The topics discussed were physician-driven and focused primarily on a biomedical agenda.
Although the qualitative research in the studies described above extends beyond quantitative self-reported data to offer some insight into the details of the interactional content of physician-patient palliative care and end-of-life consultations, it provides little elucidation of the orderly collaborative production of palliative care and end-of-life discussions (e.g., physicians’ processes for assessing patients’ physical pain). The quasi-CA studies conducted by Rogers and Todd (2000, 2010) and Öhlén and colleagues (2008) attempted to provide more detail, but their analysis did not demonstrate the value of CA as convincingly as when it is implemented rigorously.

In addition to the empirical literature, there is a substantial body of literature based on practice or clinical experience that identifies recommended or best practices for physicians when communicating with patients in palliative and end-of-life care situations. These best practices are presented in the literature in one of two ways: (a) as steps physicians should follow (e.g., Barclay et al., 2007; Buckman, 2001; Cooley, 2005; Schofield, Carey, Love, Nehill, & Wein, 2006), or (b) as key communication behaviours physicians should avoid or cultivate (e.g., Back et al., 2005; Jeffery, 1998; Mount, 1998; Ragan et al., 2008; Wilkinson, 2003/2011). A major problem with the recommended communication practices in this literature is that the information is too general (e.g., give a warning shot for any bad news, recognize and allow emotions, frequently encourage feelings and empathize). As well, much of the practice-based literature that instructs physicians on good communication practices constructs recommendations as actions that only physicians need to perform or avoid, rather than also highlighting jointly accomplished endeavours that involve both the physician and patient (e.g., Lussier & Richard, 2004; Sparks, Villagran, Parker-Raley, & Cunningham, 2007; Wilkinson,
2003/2011). For example, physicians need to: (a) actively show interest and encourage patients to continue talking (i.e., to elaborate on their answers); (b) use open-ended questions to provide room for patients to express themselves; (c) avoid normalizing statements; (d) avoid false or premature reassurance; and (e) avoid leading questions or questions that restrict the range of possible responses (Wilkinson, 2003/2011).

Another major problem with the recommendations for communication practices based on clinical experience is that these recommendations are not empirically grounded and they may not be applicable in all cases. For example, the recommendation that physicians should use open-ended questions is a broad statement that does not consider that there are times during the physician-patient consultation when patients may demonstrate that an open-ended question is inappropriate. Conversation analytic research conducted by Robinson (2006) found that the use of open-ended questions is effective for encouraging patients to elaborate new concerns about which the physician has no prior knowledge (e.g., How can I help you today? What brings you in to see me today?). However, if a patient tells a nurse about the new concern prior to seeing a physician (and the nurse notes the concern in the patient’s file), the patient will often treat a new concern open-ended question as problematic (e.g., delay responding via pauses, saying “uhm” or “ah,” and beginning answers that are cut off and restarted after a pause) because “speakers do not normally tell recipients news that speakers figure that recipients already know” (Terasaki, 1976 as cited in Robinson, 2006, p. 26). Since the patient already told the nurse about the new concern, and the patient is aware that the physician has that information in the patient’s file, an open-ended question at this time would seem inappropriate to the patient. It would be more appropriate for the physician to ask a
closed-ended question such as “You are having problems with your knee?” that seeks confirmation of the information the patient has already provided.

Other problems with the recommendations in the experience-based literature are that they: (a) isolate the recommended actions from specific contexts of use; and (b) lack sufficient detail about the possible enactments of the actions. For example, it is a common procedure in general medical education, and in the practice of most areas of medicine, to assess patients’ physical pain using the mnemonic PQRST (see Barnard & Gwyther, 2006; Gillespie & Melby, 2003; Perron & Schonwetter, 2001). Each letter represents an aspect of pain a medical professional should pursue when assessing a patient’s experiences of physical pain. Generally, the mnemonic is described as follows:

- **P** = Precipitating/provoking/aggravating or relieving factors: Seeks information about what causes the pain, makes the pain better or worse, and/or increases or decreases the intensity of the pain.

- **Q** = Quality: Seeks information about what the pain feels like (e.g., sharp, dull, present).

- **R** = Radiating: Seeks information to determine if the pain goes from one area to another.

- **S** = Site and severity: Seeks information about the physical location of the pain and the intensity of the pain (e.g., the severity of the pain on a scale of 1 to 10).

- **T** = Timing and treatment: Seeks information about when the pain started; the duration of the pain; if the pain is constantly present or if it comes and goes;
what happened before, during and after the pain; and the perceived
effectiveness of the various treatments.

The range of aspects included in the PQRST mnemonic illustrates the complexity
of assessing patients’ physical pain. However, the generalization of the mnemonic across
a wide variety of medical fields does not take into consideration the specific medical
contexts in which patients’ physical pain is to be assessed (e.g., palliative care, surgical
units, acute care facilities, long-term care facilities). Currently, there is no published
empirical research that supports the assumption that the mnemonic is appropriate and
inclusive enough to be used across medical fields.

Also, there are some important implicit assumptions inherent in the aspects of the
mnemonic that, due to their implicit nature, may not be fully explored by less
experienced physicians. Specifically, the mnemonic presupposes that a patient has
physical pain and that he or she is able to articulate specific details about the pain (e.g.,
the quality, specific precipitating and/or relieving factors). The mnemonic does not
explicitly instruct a physician on how to initially determine if a patient is experiencing
pain before pursuing a description of the pain. As well, experiences of pain are subjective
and it may be difficult for patients who are experiencing a new type of pain to articulate
the various aspects of the pain. The mnemonic does not guide physicians on what to do
when patients are unable to articulate their experiences of pain.

Also, several of the aspects of pain within the mnemonic imply a change of some
sort in the experience of pain. For example, for a pain to be radiating, it must change
location. For a pain to have been precipitated, a pain must have changed suddenly from a
less noticeable state to a more noticeable one because of an event or action. Effective
pain management requires that a physician understand: (a) the nature of a patient’s experience of physical pain; (b) what effects change in the pain; and (c) how a change in pain is manifested (Perron & Schonwetter, 2001). However, use of the mnemonic might mean that physicians fail to ask explicitly if the experience of physical pain has changed in some way (e.g., from less severe to more severe, from a sharp pain to a dull ache). It is possible that less experienced physicians trained to assess pain with the mnemonic may miss explicitly asking about changes in patients’ experiences of pain. Currently, there is no published qualitative research exploring the sequential features of interactions between physicians and patients when physicians use the PQRST mnemonic to assess patients’ pain. Consequently, it is difficult to determine if the mnemonic is being enacted in medical environments the way that it is described in the practice-based literature.

According to Arnold (2003), there is a substantial literature (quantitative, qualitative and experience-based) instructing physicians how to communicate more effectively with patients, as well as numerous studies exploring patients’ perceptions of their relationships with physicians. However, Arnold contends that “Neither of these advances the science of doctor-patient communication a great deal. We need to know the details of what is said and how it is said” (Arnold, 2003, p. 191). Generally, people’s reported perceptions of interactions deviate (sometimes significantly) from “how interactions reported on actually get done, in part because self-reports offer only general depictions of detailed and contingently organized interactional involvements” (Atkinson & Heritage, 1984, as cited in Beach & Anderson, 2003, p. 2; see also Cegala, 1997). What is needed is systematic analysis of naturally occurring interactions between physicians and patients with life-limiting illnesses that generates knowledge about the
ways in which patients and physicians “actually talk through diverse predicaments associated with illness, including distinctive patterns through which troubles involving communication arise and are resolved (or not)” (Beach & Anderson, 2003, pp. 1). The lack of empirical research exploring the dynamics of these physician-patient interactions is a gap that requires attention (Aldridge & Barton, 2007; Arnold, 2003; Cegala, 1997).

**CA Research in Medical Contexts**

In the past decade there has been a significant increase in physician-patient interaction research in the CA literature. The goal of CA research is to study (i.e., observe, describe, analyse and understand) aspects of social life (e.g., talk and non-verbal actions) in which people are collaboratively working to accomplish something (Heritage & Clayman, 2010; Sidnell, 2010; ten Have, 2007). CA focuses on naturally occurring interactions between people as a means of understanding how conversational utterances “accomplish actions and activities without necessarily formulating them as such” (e.g., informing, complaining, giving advice, describing, requesting) (Maynard & Heritage, 2005, p. 429). CA does not determine whether participants “mean what they say,” what people are “thinking or feeling” (Maynard & Heritage, 2005, p. 429), or whether a participant’s action is a reflection of an abstract quality (e.g., medical power). CA does not attempt to prove or provide support for theories in the usual sense (Sidnell, 2010; ten Have, 2007) (e.g., conduct experiments or distribute quantitative surveys as a means of acquiring evidence to support theories such as attribution theory [i.e., the ways in which people attribute causes to events regarding the behaviours of others; Weiner, 1980]). Although it may thus appear that CA is atheoretical, this is not the case. CA adheres to an ethnomethodologically based meta-theory that underpins the analytic strategy. The meta-
theory has two foci. The first focus is on identifying the “inherent theories-in-use” of participants’ situated actions as “lived orders” (ten Have, 2007, p. 31; see also Sidnell, 2010). That is, CA is used to obtain an understanding of various collaborative practices of human conduct and to describe in formal language particular aspects of those practices (Sidnell, 2010). This understanding is expressed in the form of identified patterns of interaction. The second focus is on the ways in which participants orient themselves to certain norms, rules and expectations (ten Have, 2007, p. 37).

In the medical context, the majority of the CA research is being conducted in primary and acute care environments. This body of research spans a breadth of topics, for example:

- sequence organization of physician-patient interactions in acute primary care encounters (e.g., Heritage & Maynard, 2006; Robinson, 2006);
- treatment proposals (Heritage & Sefi, 1992; Stivers, 2006);
- physicians’ opening questions (Heritage & Robinson, 2006b; Robinson & Heritage, 2005);
- the solicitation of patients’ concerns (Robinson, 2006);
- patients’ narratives of symptom discovery (Halkowski, 2006);
- patients’ proposals for explaining illness and physicians’ responses (Gill & Maynard, 2006);
- the ways in which patients make sense of and resist diagnostic activities (Gill, Pomerantz, & Denvir, 2010);
- the ways in which patients accomplish a request without making one (Gill, Halkowski, & Roberts, 2001);
the ways in which physicians deny patients’ requests (Paterniti, Fancher, Cipri, Timmermans, Heritage, & Kravitz, 2010);

the coordination of verbal and non-verbal behaviours in medical consultations (Heath, 1984, 2002);

the use of small talk in medical visits (Maynard & Hudak, 2008);

the ways in which missing assessments influence the physician-patient interaction (Jones, 2001);

alignment and affiliation in talk in medical encounters (Jones, 2001);

empathetic talk in medical interactions (Beach & Dixson, 2001; Beach & LeBaron, 2002; Ruusuvuori, 2005);

questioning in medical interactions and the role of epistemics (Heritage, 2010);

the sequence organization of patients’ talk when they describe experiences of pain (Heath, 1989); and


It is not possible in this space to describe the details of all of the CA research in medical contexts. Instead, I describe here the findings from some physician-patient interaction CA studies that are particularly relevant to my analyses in Chapter 5: Assessing Physical Pain II – Questions and Answers: medical question design and patient answers; patterns of elaboration in a medical context. Also, I report the ways in which CA has been used to examine interactional data involving physicians and patients during cancer care consultations.

Medical question design and patient answers. Question design involves a “multitude of features” (Heritage, 2010, p. 44). The features that are relevant to my
research are: the four basic dimensions of question design (i.e., agendas, presuppositions, preferences [Boyd & Heritage, 2006; Heritage, 2010], and epistemic stance [Heritage, 2010]); the principles of optimization (Boyd & Heritage, 2006; Heritage, 2010) and recipient design (Boyd & Heritage, 2006; Heritage, 2010); the principle of problem attentiveness (Heritage, 2010; Stivers, 2007); some devices that facilitate the progressivity and cohesiveness of the talk (i.e., and-prefaces [Heritage and Sorjonen, 1994] and the routine checklist objective [Stivers & Heritage, 2001]); reasons for medical visits (Robinson, 2006); and the use of deictics (e.g., here, there) and physical gesticulations (e.g., pointing, rubbing areas of the body) to indicate the site of a symptom (Heath, 1989).

**Four basic dimensions of question design.** Boyd and Heritage (2006; see also Heritage, 2010) looked at the design of physicians’ questions asked during history-taking. Specifically, they focused on the “expectations, presuppositions, and concerns that physicians’ questions about the patient’s personal history unavoidably embody” (Boyd & Heritage, 2006, p. 153). The authors argue that physicians’ questions have at least three features: they (a) establish specific agendas (topic and action) for the patient’s answer; (b) embody presuppositions about different aspects of the patient’s health, awareness of his/her body, and background medical knowledge and (c) incorporate preferences (i.e., invite one type of answer over another) for the patient’s answer. A patient can formulate an answer in a way that accepts, resists or completely rejects the agenda set by a physician’s question; confirms or disconfirms the presuppositions; and aligns or disaligns with the preferences. Boyd and Heritage (2006) contend that the three dimensions of questions (agenda, presuppositions and preferences) are:
fundamental and inexorably relevant characteristics of question design and production...it is not possible to avoid them, physicians’ questions can only select between different possibilities...these selections are crucial for the work that questions do, and the kind of physician-patient relations which are conveyed through that work. (Boyd & Heritage, 2006, pp. 154-155)

Agenda. The agenda consists of two components: topic and action (Boyd & Heritage, 2006). The topic agenda of a question is the particular issue to which the question is addressed. The action agenda is the particular restricted action that a physician is requesting a patient to perform by the type of question that is asked: answering yes or no (or some token akin to this such as yep, yeah, nope, or nah) to yes/no interrogative (YNI) and yes/no declarative (YND) questions; choosing one of the offered options in an alternative question (ALT-Q); and giving the information made relevant by a WH-question (WH-Q; who, what, where, when, why and how questions) such as a location for a where question or a description for a how question. If a patient’s answer aligns with the action agenda of the question (i.e., is type-conforming in that it provides the action made relevant by the question such as yes or no to a YNI), by definition it conforms to or accepts the topic agenda. However, patients often provide answers that resist or subtly deviate from the agenda of the physician’s question. An answer that is not type-conforming (i.e., does not accept the agenda-setting function of the question) usually indicates that a patient views something about the question as problematic (e.g., the question is inappropriate for or insensitive to the current situation). For example, a patient may reject the agenda of a physician’s question by providing an account for an answer to

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10 This is not always the case for where questions; see Heritage (2010) and Heritage and Clayman (2010) for examples of exceptions.
a YNI or YND rather than a simple yes or no, such as Q: “Are you exercising regularly?”; A: “I’ve been so busy at work and my daughter has been sick a lot so I haven’t had a chance.” In this case, the patient does not state yes or no anywhere in her answer; therefore, her answer is not type-conforming and she rejects the action agenda. Further, she uses an account (i.e., busy at work and daughter sick a lot) to justify the deficiency in her behaviour (i.e., not exercising regularly) as a means of pre-empting a negative evaluation by the physician. According to Heritage (2010), examining how physicians’ questions set agendas, and how patients respond to these agendas, can help us to better understand the ways in which physicians and patients “both cooperate and struggle with one another over ‘what matters’ in a given medical context” (p. 46). In these types of interactions, both a physician and a patient become privy to the other’s immediate concerns and the ways through which these concerns develop. During these interactions, information is being “exchanged” (Heritage, 2010, p. 46; see also Cassell, 1985, 1991), negotiated and understood.

**Presuppositions.** All questions include presuppositions about “aspects of the patient’s life circumstances, health status, bodily awareness, and medical knowledge with varying degrees of explicitness” (Boyd & Heritage, 2006, p. 159; see also Heritage, 2010). For example, a physician asks a female patient “What type of birth control are you using?” The presuppositions embodied in this question are that the patient: (a) is able to get pregnant; (b) is sexually active; (c) does not want to have a child at this time; and (d) currently uses some form of birth control. The presuppositions in physicians’ questions have implications for patients’ answers. That is, the patient’s answer may display that one
or more of the presuppositions in the physician’s question are inappropriate given her particular history. For example, an answer from this patient such as “I stopped taking the pill after the menopause” disconfirms the first presupposition (i.e., she is not able to get pregnant) and the fourth presupposition (i.e., she does not use birth control as it is not necessary) embodied in the physician’s question.

Preference. Physicians’ questions may be designed with a bias or tilt that favours, prefers or suggests an expectation for one answer over another11 (Boyd & Heritage, 2006; Heritage, 2010). Preference is usually “accomplished through a combination of grammatical structure and lexical choices that are built to structurally favour ‘yes’ or ‘no’ answers” (Boyd & Heritage, 2006, p. 160). For example, the following questions are grammatically designed to favour yes-type answers: “Are you in pain?” “You’re in pain, aren’t you?” “You’re in pain currently?” “Aren’t you in pain?” In contrast, the following questions are grammatically designed to favour no-type answers: “There’s no pain in your back.” “There’s no pain in your back is there?” “No pain in your back?” Heritage, Robinson, Elliott, Beckett, and Wilkes (2007) found that questions that are grammatically structured to prefer a yes-type answer (i.e., as illustrated above or with the inclusion of the positive polarity item “some”) can have their preference reversed with the inclusion of a negative polarity item (e.g., any, ever, at all).

An answer from a patient that aligns to the preference in the question (i.e., a preferred answer) is usually delivered in a brief, simple fashion, and with little or no delay. In contrast, Heritage (1984) states that an answer that disaligns with the preference (i.e., a dispreferred answer) contains one or more of the following characteristics:

11 Preference in this context relates to the “interaction-structure features of the organization of the sequence and practices of questions” that favour a particular answer; it is not about individual wishes, desires, hopes, wants, etc.” (Schegloff, 2007, p. 81).
a) Delays, such as a pause before delivery, the use of a preface, or displacement over a number of turns via the use of insertion sequences;

b) Prefaces, such as markers like *uh* or *well*, token agreements, appreciations and apologies, qualifiers, or hesitation;

c) Accounts, in particular, explanations for why the relevant or proposed action is not being accepted or done; and

d) Declining, which is normally mitigated, qualified or indirect. (Heritage, 1984, pp. 266-267)

*Epistemic stance*[^12]. In every interaction between two or more people, at least one person in the interaction is in a position of some knowledge regarding a topic that is discussed (Heritage, 2010). Epistemic stance refers to “how speakers position themselves in relation to each other in and through the design of their turns at talk” (Heritage 2012b, p. 2; see also Heritage & Clayman, 2010). That is, by virtue of asking a question that seeks information, a speaker positions himself/herself in a relatively unknowing (K-) epistemic stance in relation to a projected knowing (K+) stance of the respondent for the topic being discussed (Heritage, 2010; Heritage & Clayman, 2010). The K- epistemic stance of the speaker varies slightly depending on the type of question (i.e., YNI, YND, ALT-Q or WH-Q) the speaker asks. That is, a speaker can position himself/herself as

[^12]: The literature related to epistemics is varied, evolving, and at times inconsistent. For example, Stivers (2005) discusses “primary epistemic rights over a claim” (Stivers, 2005, p. 133), “epistemic independence” (Stivers, 2005, p. 135), and “epistemic authority” (Stivers, 2005, p. 136). Raymond and Heritage (2006) interchange the terms “epistemic authority” and “epistemic superiority” (Raymond & Heritage, 2006, p. 677). Gardner (2007) refers to epistemic authority as “epistemic priority” (Gardner, 2007, p. 319). Heritage (2010; 2012b) equates epistemic authority with epistemic status and epistemic rights with epistemic stance. I recognize that discussion of epistemics is relevant to the analysis of the data in this study. However, due to the evolving and varied nature of this domain, I have chosen to limit my discussion to Heritage’s (2010) concept of epistemic stance as it relates to the analysis of questions in a medical context. My reason for choosing Heritage’s (2010) version of epistemic stance is that it builds on his work in Boyd and Heritage (2006) in that he adds epistemic stance as the fourth basic dimension of question design in medical contexts.
more K- (i.e., significantly less knowledgeable than the respondent) by asking a YNI or a WH-Q because these types of questions seek an answer and encourage elaboration and sequence expansion from the respondent who is projected as a more knowledgeable source. In contrast, a speaker can position himself/herself as less K- (i.e., more knowledgeable than if he/she asked a YNI or WH-Q, but less knowledgeable than the respondent) by asking a YND or an ALT-Q because these types of questions demonstrate some knowledge about the topic of discussion: a YND question only seeks confirmation of knowledge and an ALT-Q seeks a choice between two possible options. Further, the designs of a YND and an ALT-Q discourage elaboration from a respondent (Heritage, 2010; Heritage & Clayman, 2010).

In providing the speaker with a relevant answer, the respondent demonstrates a K+ epistemic stance (Heritage, 2010; Heritage & Clayman, 2010). When people are asked about personal information, their K+ epistemic status can be inferred based on the premise that people are generally treated as having more knowledge about their experiences, feelings, thoughts, hopes and expectations than do others (Heritage 2012a; Sacks, 1984). The K+ epistemic stance of the respondent varies slightly depending on the type of answer the respondent provides (Heritage, 2010; Heritage & Clayman, 2010). That is, a respondent can position himself/herself as more K+ (i.e., significantly more knowledgeable than the speaker) if the respondent provides an elaborated answer. In contrast, a respondent can position himself/herself as less K+ (i.e., slightly more knowledgeable than the speaker), e.g., by providing only the required type-conforming yes- or no-type answer to a YNI or YND. A minimal answer demonstrates some knowledge about the topic of the question but how much knowledge is not elucidated.
Further, devices such as epistemic downgrades (e.g., *I think*) are another way for respondents to position themselves as less K+. But ultimately, any type of relevant answer from the respondent demonstrates his/her K+ epistemic stance (Heritage, 2010; Heritage & Clayman, 2010).

In some cases, the respondent does not respond to the speaker’s question (Heritage, 2010; Heritage & Clayman, 2010). In these instances, the respondent demonstrates a reluctance to assume a K+ stance at that point in the conversation with regard to the topic of the question. Since medical questions are usually about a patient’s subjective experiences, not responding to a physician’s question does not necessarily mean that the respondent is not knowledgeable about the topic of the question. Rather, it is more likely that the respondent views something problematic about the question and that this is what is preventing his/her immediate answer (Heritage, 2010; Heritage & Clayman, 2010).

**Principle of optimization and the principle of recipient design.** Boyd and Heritage (2006; see also Heritage, 2010) also elucidate two principles of routine medical questioning: the principle of optimization and the principle of recipient design. According to the authors, “medical questioning that embodies these two principles will generally tend to be heard as sensitive, concerned, and caring” (Boyd & Heritage, 2006, p. 164).

**Principle of optimization.** Physicians’ questions that embody this principle incorporate presuppositions and preferences that are biased towards “best case or no problem outcomes” (Boyd and Heritage, 2006, p. 164) for a patient’s health or life circumstances. These types of questions are designed to confirm or disconfirm whether a problem exists. A question displays the principle of optimization when the preferred
answer confirms a positive health outcome. For example, the question “Is your foot healed?” prefers a yes-type answer, which would be the positive health outcome for a patient. Another example is “Do you have any pain in your foot?” Pain in the foot is a negative health outcome, but the preference for a no-type answer (because of the negative polarity item any) aligns this question toward a positive health outcome. In contrast, asking “You’re in pain aren’t you?,” which prefers a yes-type answer, would not display the principle of optimization because experiencing pain is not a positive health outcome for a patient. According to Heritage (2010), the principle of optimization is a “fundamental ‘default’ principle of medical questioning...and unless there is some specific reason not to do so, medical questioning should be designed to allow patients to confirm optimistically framed beliefs and expectations about themselves and their circumstances” (Heritage, 2010, p. 14).

In the present study’s palliative care context the supervising physician’s briefing of residents before the consultation with the patient informed them that the optimal health outcome for patients attending the Clinic is that the patients’ condition remain stable. Questions that are consistent with such an outcome would include those that indicate no change in pain, no new pain, and/or pain that is managed but not likely to be eliminated. Physicians’ questions designed for a ‘no pain’ answer (which would be an optimal health outcome in many other medical contexts) would thus be inconsistent with the nature of this palliative context (i.e., ‘no-pain’ questions might seem overly optimistic).

*Principle of recipient design.* The default principle for ordinary conversations is the principle of recipient design (Sacks, Schegloff, & Jefferson, 1974). That is, speakers design their talk to display an “orientation and sensitivity to the particular others who are
the co-participants” (Sacks et al., 1974, p. 727) in the conversation. During questioning situations such as the medical routine checklist (i.e., a general set of questions that physicians ask every patient during history-taking such as “Any family history of heart disease?” “Any history of diabetes?” [see Stivers & Heritage, 2001]), it is considered appropriate for physicians to design their questions to align with the optimized health outcomes for patients using a generalized recipient design (Boyd & Heritage, 2006; Heritage, 2010). That is, the questions asked are standard for all patients. However, in some instances (i.e., initial visits to a physician, well visits and yearly checkups) physicians need to temper some of their optimized questions to display a realistic consideration that the optimized answer may not be likely in a given situation (i.e., a more narrow form of the principle of recipient design). For example, if during a yearly check-up it has been determined that a patient has gained 15 pounds, is hypertensive and is working 50 hours a week in a family business, recipient design would dictate that asking the patient “You’ve been exercising have you?” (an optimized question), would be inappropriate. Rather, the more realistic question would be “Are you able to exercise at all?” The negative polarity of the tag phrase “at all” prefers a no-type answer, which would not be the positive health outcome for the patient but is more likely given the patient’s life circumstances.

**Principle of problem attentiveness.** Stivers’ (2007) research builds on Boyd and Heritage’s (2006; see also Heritage, 2010) research with the addition of the principle of problem attentiveness in contrast to the principle of optimization. Analyzing data collected during acute care visits, Stivers (2007) contends that it would seem inappropriate for physicians to design their questions to display the principle of
optimization when asking patients about the symptoms that are the reason for the medical visit. Juxtaposed with this is that if a patient mentions a particular symptom, then the physician should design questions that are broadly in line with that symptom and that are designed to presuppose that there is a problem (i.e., display the principle of problem attentiveness). For example, if a patient makes an appointment to see his/her doctor because he/she is experiencing pain in his/her back, it would be inappropriate for the physician to ask the patient “You don’t have pain in your back, do you?” Rather, it would be more appropriate for the physician to ask the patient a question such as “How long have you had pain in your back?”

*Progressivity and cohesiveness of the talk.* Heritage and Sorjonen (1994) examined physicians’ use of *and*-prefaces in medical questions. They found that by beginning a question with *and*, physicians link this question to preceding question/answer adjacency pairs (Q/A-APs)\(^\text{13}\), and questions designed this way aid in facilitating the progressivity and cohesiveness of the talk. *And*-prefaced questions are not commonly used in ordinary conversation; they are more generally used in interactions in institutional settings (e.g., medical encounters, law courts) where speakers have a specific set of tasks that need to be performed during the interaction. An *and*-preface to a question in a medical context indicates that this question has a “routine or agenda-based character” (Heritage & Sorjonen, 1994, p. 1). That is, the *and*-preface is a resource that “invokes and sustains an orientation to an activity or course of action that is implemented through a series of question/answer pairs, but transcends any individual pair” (Heritage & Sorjonen, 1994, p. 1).

\(^{13}\) Q/A-APs are questions and answers that are sequentially organized in the talk (Schegloff, 2007). An explanation of adjacency pairs is provided in Chapter 2 and an explanation of Q/A-APs is provided in Chapter 5 and Appendix A: Glossary.
In a medical context, the progressivity and cohesiveness of the talk also can be facilitated via the routine checklist objective (Stivers & Heritage, 2001; also see Boyd & Heritage, 2006; Heritage 2010). Stivers and Heritage analyzed primary care physician-patient interactions, focusing on the history-taking component of the consultation. The authors state that it was a common practice for physicians to use restrictive, routine checklist-type questions at the history-taking stage of the consultation which expedited the progressivity of the talk and created cohesiveness to the medical questioning. Specifically, physicians asked a series of questions that required patients to only answer yes or no (or a similar token such as yeah or nope) or to make incomplete brief statements (e.g., simply naming a body part when asked where there is pain). The routine checklist activity usually involved a physician asking the first question as a fully formed yes/no interrogative (YNI) or yes/no declarative (YND); each successive question then became more truncated than those prior in a process of ellipsis: for example, “Have you ever been diagnosed with diabetes?,” “And any high blood pressure?,” “Heart problems?”

Reasons for medical visits. Robinson (2006) examined the different types of reasons patients gave for visiting their primary care physician. He found that patients usually gave one of three reasons for their visit: (a) relatively new concerns “that are being presented for the first time to a particular physician or clinic, or for the first time since previously being ‘cured’” (Robinson, 2006, p. 23); (b) follow-up concerns that were previously discussed, for which an action was recommended and for which a return visit is a means of following up or checking on a patient’s recovery or progress; and (c) chronic-routine concerns that are symptoms or situations that are “generally ongoing but under control, such as blood pressure and diabetes, and that are dealt with on a regular
basis” (Robinson, 2006, p. 23). Robinson found that the design of the physicians’ questions (i.e., the assessing or soliciting questions) is different depending on patients’ reasons for seeing the physician. For example, Robinson (2006) reported that physicians generally ask a question such as “What’s going on today?” or “How can I help you today?” (Robinson, 2006, p. 25) for new concern visits; “How is it?” (Robinson, 2006, p. 29) or “How is the dizziness now?” for follow-up concerns; and “How has the arthritis in your hands been lately?” for chronic-routine concerns (Robinson, 2006, p. 36). An interesting finding reported by Robinson is that “What’s new?” or “Anything new?” (Robinson, 2006, p. 36) type questions simultaneously deal with new concerns and chronic-routine concerns in chronic-routine visits.

**Deictics and physical gesticulations.** Heath (1989) examined patients’ verbal expressions of physical pain during physical examinations and history-taking. The data analyzed were naturally occurring physician-patient interactions in primary health care or general practice consultations. Heath found that while replying to history-taking questions, patients commonly used deictics (e.g., here, there) and physical gesticulations (e.g., pointing, rubbing areas of the body) to indicate the site of their physical pain. Heath argues that patients imbue their turns at talk with verbal cues and physical gesticulations to describe and present their suffering.

**Patterns of elaboration in a medical context.** Elaborated answers to physicians’ questions can be an effective means by which: (a) patients can report information about their situation; and (b) physicians can obtain history and symptom details necessary for assessing patients’ medical condition, arriving at a diagnosis and developing a treatment plan (Stivers & Heritage, 2001). Given that elaboration is important to the issue of
disclosure in medical contexts and is highly relevant to the analyses in my dissertation, the patterns of elaboration in medical contexts that have been identified in CA research are presented in this section\textsuperscript{14}.

Stivers and Heritage (2001) found that the design of a physician’s questions in the routine checklist situation places constraints on a patient’s next action (i.e., discourages elaboration by requiring only brief answers) and the checklist questioning discourages patients from expressing lifeworld concerns. The authors offer several examples of a series of questions to which patients provide the required brief answers. The authors argue that by providing only minimal answers patients demonstrate an orientation to the checklist history-taking as a “distinct activity within the medical consultation” (Stivers & Heritage, 2001, p. 178). As well, physicians and patients are said to demonstrate an understanding that the series of questions embodied a checklist quality. This is not to say that patients always give minimal answers to routine checklist questions. Stivers and Heritage (2001) found that some patients went beyond just answering the questions and elaborated on their answers to give the more information than was required.

Stivers & Heritage (2001) divided patients’ expansive answers into two broad types: expanded answers and narrative expansions. Expanded answers involve the patient providing the required answer and a brief elaboration. Expanded answers give added support to the answer (e.g., answering “Yes, every day” to the doctor’s question “Are you taking your medication?”) or provide acknowledgment of some deficiency in behaviour as a means of pre-empting a negative evaluation by the physician (e.g., responding “No, I know I should” to the physician’s question “Do you exercise regularly?”). In contrast,

\textsuperscript{14} To date, there is no one CA publication that explicitly outlines the patterns of elaboration for all of the types of questions.
narrative expansions are a more extensive expansion than expanded answers. They allow a patient to deviate from the physician’s agenda for the visit to a personal agenda of concerns. Narrative expansions are patient-initiated, are not part of the answer to the just prior question (nor part of clarifying a just provided answer), and usually involve a patient giving the physician some insight into a patient’s life circumstances. These elaboration or expansions take one of two forms: a small-scale telling or a full-blown narrative. Both forms accomplish the same action; they allow a patient to exploit the medical context to present a concern that was “apparently ‘on the patient’s mind’” (Stivers & Heritage, 2001, p. 165).

In addition to the routine checklist discouraging elaboration, other research has identified relationships between elaboration and a number of the features of questions, such as:

- YNIs that prefer yes encourage elaboration (Heritage, 2010; Raymond, 2010) unless they are optimized: optimized YNIs discourage elaboration (Heritage, 2010).
- YNIs that prefer no (e.g., that contain a negative polarity item such as any) discourage elaboration (Heritage, 2010; Heritage et al., 2007)
- YNIs that display problem attentiveness encourage elaboration (Stivers, 2007; see also Heritage, 2010).
- YNDs discourage elaboration regardless of optimization or preference (Heritage, 2010; Raymond, 2010).
• Dispreferred answers to YNIs and YNDs generally include elaboration (in the form of accounts or explanations) regardless of the question’s design (Heritage, 1984, 2010).

• *What, why* and *how* questions are telling questions that encourage elaborated answers (e.g., reports, stories) (Fox & Thompson, 2010; Heritage, 2002).

• *Who, when* and *where* questions are specifying questions that seek specific pieces of information and encourage a concise answer with little elaboration (Fox & Thompson, 2010; Heritage, 2002).

• The use of an ALT-Q makes relevant an answer in which the respondent repeats one of the provided answer options and elaboration is discouraged (Koshik, 2005; Stivers, 2010).

**Cancer care consultations.** Although there are no published CA studies exploring physician-patient interactions in palliative care environments, several researchers (e.g., Beach, Easter, Good, & Pigeron, 2005; Lutfey and Maynard, 1998) have used CA to examine interactional data involving physicians and patients during cancer care consultations. Beach and associates (2005) examined “how patients demonstrate and doctors respond to ‘fears’ about cancer” (Beach et al., 2005, p. 893). They found that while patients elaborated on their answers and initiated discussion about their concerns, they displayed fear regarding their diagnosis of cancer. For instance, when a female patient discussed her past medications with the oncologist, she informed the physician that she had taken viral suppressants. After a brief pause, she went on to volunteer that she took this medication because of her previous incident of cancer. When the doctor asked her if she had had any chemotherapy at that time, she shook her head
and said “Cause they got it (0.2) early enough” (Beach et al., 2005, p. 896). Although the patient essentially communicated good news (her cancer was caught and stopped at an early stage), her body language at the time of dispensing this good news indicated what was described by Beach and associates (2005) as a fear response. She became “squirmy,” crossed her legs and did two small leg kicks, she was unable to keep eye contact with the doctor, and she closed her eyes and paused briefly between the words “it” and “early.” The authors argue that the patient’s body language provided visible evidence of the delicacy of her disclosure and that she experienced what could be described as fear as a result of her current medical situation, which was reminiscent of her previous potentially fearful experience with cancer. As well, by not naming her cancer (using “it” instead), the patient distanced herself from her past experience with cancer, and her current body language demonstrated a need to do the same in the present situation (Beach et al., 2005).

In responses to the patient’s disclosure, the physician did not make eye contact with the patient and only said “Okay, good” (Beach et al., 2005, p. 898). The patient then nodded and smiled, but the smile quickly turned to a tight-lipped grimace. The patient continued looking at the physician but the physician offered no further elaboration; rather, he averted his eyes and remained silent for ten seconds. Then the physician met the patient’s gaze and asked “hhh How have you been feeling (.) lately?” (Beach et al., 2005, p. 898). By asking the patient about her condition “lately,” the physician attempted to move forward his medical agenda. While the physician talked, the patient continued to grimace and met his gaze, but upon completion of his question she averted her gaze up and to the left and appeared to be searching for an answer. These actions indicated that the patient did not receive the response or reassurance that she expected from the doctor,
and her fears about cancer and her current condition were not set to rest. In their analysis of this interaction, the authors demonstrated how the patient’s verbal and non-verbal actions of exhibiting fear failed to occasion the desired response from the physician, that is, acknowledgement of the patient’s lifeworld disclosures. This is only a small sample of the detailed information provided by the Beach and associates’ (2005) study. Analysis of several physician/patient oncological interactions allowed Beach et al. (2005) to establish regularities in the organization of participants’ talk when discussing cancer.

Lutfey and Maynard (1998) examined how a physician and his patients collaboratively achieved an understanding of death and dying without using those words. Their data consisted of three video-taped medical consultations in which the same physician told three patients that their cancer was no longer treatable. In the physician’s conversation with the patient John the physician hinted at the likelihood that John’s condition would significantly deteriorate if he went home. Initially, John emphatically stated he would be fine to go home. However, as the conversation continued, John began to change his stance, and at the end of the conversation he subtly displayed his understanding that curative treatment would no longer help him, that if he went home his condition would deteriorate, and that his condition was terminal. This change in John’s understanding of the situation was completed without the physician or John using the words dying, death, hospice, terminal, or palliative care. For example, the physician asked John, “Do you have a sense of (0.6) what’s happening with the (. ) melanoma? What the illness is doing: r-right now, how it’s affecting you? (2.6)” (Lutfey & Maynard, 1998, p. 334). John responded, “Yeah, I have a sense of it fer SURE= (0.6) Absolutely.”
general category of cancer, was a cautious approach to discussing the severity of John’s condition; it was a way to soften the impact of the situation. The term cancer carries with it negative connotations and has the potential to produce fear and anxiety in many people (as was displayed in the research of Beach et al. [2005] previously discussed). Further evidence of the physician’s attempt to soften the delivery of bad news was his use of the phrases “what’s happening with the melanoma,” “what the illness is doing,” and “how it’s affecting you” (Lutfey & Maynard, 1998, p. 334). The phrases incorporate euphemisms and allusions that gloss over the dying process. Further, their use within this one turn-at-talk demonstrates a three-part list. Jefferson (1990) argues that speakers can use three-part lists to accomplish several different interactional tasks. One task that can be enacted is introducing, in the third position on the list, a point that might offend or upset the recipient of the turn. The authors argued that this was what the physician was doing (Lutfey & Maynard, 1998). That is, the progression in this three-part list moved the direction of the illness from being distant from John (i.e., “what’s happening with the melanoma” and “what the illness is doing”) to directly relating to John (i.e., “how it’s affecting you”).

John’s answer to the physician’s turn, “Yeah, I have a sense of it fer SURE= (0.6) Absolutely” (Lutfey & Maynard, 1998, p. 334) allowed John to continue with the euphemisms by referring to the terminal nature of his cancer as “it” as the physician did in the third part of his list. By using euphemisms and the indirect and allusive term “it,” both the physician and John cautiously aligned interactionally with the idea of John dying. This collaborative process continued throughout the remainder of the discussion between the physician and John and it culminated in the doctor saying “Bu:t (0.7) tchh
uhmm (0.6) we have after a lot of thought we haven’t come up with any (.). treatment for the melanoma itself,” with John replying “[r]ight (2.4) I unfortunately am quite aware of that myself” (Lutfey & Maynard, 1998, p. 337). In this interaction, the physician softened the news of John’s terminal status and John subtly acknowledged his understanding of this fact.

Using CA to Study Physician-Patient Interactions in Palliative Care

Conversation analysis (CA) can be an effective way of addressing the limitations of previous research on physician-patient communication research (e.g., offering only general depictions of medical interactions, not explaining how activities such as solicitation of symptom information are accomplished [Maynard & Heritage, 2005]). According to Collins and Britten (2006), CA’s use of a fine-grained or microanalytic strategy provides a means of studying the precise ways in which, through communication in health care consultations, patients’ concerns are presented and addressed, symptoms are described and understood, diagnoses are offered and accepted, and treatment options are negotiated and decided on. (Collins & Britten, 2006, p. 43)

In palliative care environments, healthcare providers (e.g., physicians, nurses) often act as gatekeepers who protect their patients and patients’ family members from being bothered by research activities at this difficult time in their lives (Addington-Hall, 2002). This has resulted in a dearth of empirical information about the interactional practices of physicians and patients/families in this context. To overcome palliative care practitioners’ hesitation to involve patients with life-limiting illness in communication
research studies, it is imperative to demonstrate to them that the intended research is not going to impose unnecessarily on patients/family members, and that the research results are going to inform the provision of services to patients with life-limiting illness.

One method of ensuring that patients/family members are not imposed upon to participate in data collection outside their normal activities is for researchers to access existing naturally occurring data. For example, it is a common practice in many medical teaching facilities for medical residents and supervising physicians to be video/audio-taped interacting with patients (and their family members). Analyses of video/audio-recordings of palliative care physician-patient interactions would allow CA researchers to witness the co-constructions or collaborative endeavours of physicians and patients with life-limiting illness as they occur in real time, on their own terms, and in the social context or sequence of talk in which they were located (see Beach & Anderson, 2003; Hutchby & Wooffitt, 1998; Maynard & Heritage, 2005). Collection of these naturally occurring, real-time data is less intrusive and physically taxing on patients with life-limiting illness than conducting interviews or having patients and/or their families complete questionnaires.

The rich analytic detail provided in CA research can inform physicians in palliative care environments, other healthcare providers and researchers from various disciplines about such topics as the efficiency of various symptom assessment techniques (e.g., types of questions), the quality of end-of-life care and patient/family member satisfaction with services without putting participants on the spot to explicitly assess the type of care received (see Beach & Anderson, 2003; Hutchby & Wooffitt, 1998; Maynard & Heritage, 2005). Also, the use of CA can eliminate any concerns palliative care
patients may have about their assessments of their medical care possibly jeopardizing the kind of care they receive in the future. Rather, such phenomena as efficiency of symptom assessment strategies, quality of care and satisfaction can be shown in interaction versus constructed retrospectively.

Empirical publications from CA physician-patient interaction research in palliative care environments can allow readers to observe and understand the ways in which sequence and turn-taking organization\(^\text{15}\), voice intonations, overlapping speech, body language, repetitions, silences and hesitations accomplish actions within this context (Beach & Anderson, 2003; Hutchby & Wooffitt, 1998; Maynard & Heritage, 2005). CA attends to the way in which people collaboratively manage misunderstandings, offer explanations, and assess procedures and/or actions. Also, studying the types of questions asked by palliative care physicians during consultations can reveal ordered patterns of communication.

In summary, the use of CA to study physician-patient palliative care interactions can address the limitations identified by Arnold (2003) regarding the current communication literature on this topic. That is, CA can, among other things: (a) provide details about what is being said between physicians and patients with life-limiting illness and elucidate the ways in which it is being said; (b) describe the ways in which interactions are accomplished in palliative care environments; (c) give details about orderly collaboration in end-of-life discussions; and (d) elucidate the ways in which troubles in talk between physicians and patients with life-limiting illness arise and how they are (or are not) resolved.

\(^{15}\) See Chapter 2 or Appendix A: Glossary for definitions.
Purpose of Dissertation and Research Questions

The specific focus of this research is on physicians’ questions about the patient’s experience of physical pain and the ways in which the patient answers and resists answering questions. The main research question addressed in this dissertation is: How do palliative care physicians use questions to assess the palliative patient’s experiences of physical pain and how does the patient respond? The specific sub-questions addressed are:

1) What aspects of physical pain do the physicians enquire about? How well do the aspects of pain included in the patient’s answers align with those in the physicians’ questions?

2) How are the physicians’ questions designed? What types of answers do the physicians’ questions occasion?

3) How do the physicians’ questions encourage or discourage elaboration? Do the patient’s answers conform to or deviate from the requirements of the question?

Brief Overview of Each Chapter

Chapter 2 outlines the approach to analysis. Chapter 3 outlines the background of the study, the participants and the process of data selection. Chapter 4 presents the results regarding the aspects of physical pain enquired about in the physicians’ questions and the corresponding answers from the patient. Chapter 5 presents the results regarding the physicians’ assessment of pain techniques (i.e., questions) and the patient’s next-turn answers. Chapter 6 provides a discussion of the results as they pertain to the existing literature, a consideration of the implications for CA medical research and training in
palliative care communication, and a discussion of the limitations of this study and of avenues for future research.
Chapter 2: Methodology

CA is data-driven, using naturally occurring interactions rather than those that are artificially produced (e.g., in experiments, guided interviews) (ten Have, 2007). The basic approach of CA is inductive (i.e., the process of using naturally occurring data to “formulate or reformulate a general idea;” ten Have, 2007, p. 37). Upon acquiring data, a CA researcher first uses inductive (bottom-up) search procedures as a means of determining regularities or patterns in the organizational structure of the interaction. For example, if an analyst is interested in how yes/no interrogatives (YNIs) are asked and then answered (or not), the analyst will begin by collecting many samples of YNI question-and-answer adjacency pairs (Q/A-APs)\(^\text{16}\). Then the analyst will identify patterns in the ways in which the speakers ask a YNI and the recipients of the YNI make sense of the question in their next-turn response (i.e., next-turn uptake of the prior action; Schegloff, 1991). The intent of this process is to demonstrate that the patterns are embedded in the “ordered progression of turns” (i.e., sequence organization; ten Have, 2007, p. 219) and that the participants “orient to” (Heritage, 1988 as cited in ten Have, 2007, p. 36) the patterns as normal or expected actions. In addition to looking for regular patterns, CA researchers also search for “deviant cases” (i.e., instances of a discursive action that seem to deviate from the previously constructed pattern) as a means of revising the characterization of the pattern to better reflect the talk-as-interaction. The basic analytic strategy of CA is to:

\[
\text{take what people are doing, that is saying, not-saying, saying something in a particular manner, at a particular moment, etc., and try to find out the kind of} \\
\]

\(^{16}\text{An explanation of adjacency pairs (APs) is provided later in this chapter and an explanation of Q/A-APs is provided in Chapter 5 and Appendix A: Glossary.}\)
problem for which this doing might be a solution…asking ‘why that now.’”

(ten Have, 2007, p. 16)

There are two forms of the CA approach: pure and applied (Heritage & Clayman, 2010; ten Have, 2007). Pure CA examines talk-in-interaction during “ordinary conversations – a term that has come to denote forms of interaction which are not confined to specialized settings or to the execution of particular tasks” (Heritage & Clayman, 2010, p. 15). Pure CA analysis adds to our knowledge of how social order is accomplished. Emphasis is placed on how sequence and context are linked; that is, as participants are designing their turns-at-talk (next action) they orient to the talk preceding their turn, consequently constructing and reconstructing a context for the next speaker. The production of a next action demonstrates an “understanding of the previous action, building mutual understandings or intersubjectivity” (ten Have, 2007, p. 179). Analysis of ordinary conversation has informed our understanding of the “vast array of rules and practices, which are deployed in pursuit of every imaginable kind of social goal, and which embody an indefinitely large array of inferential frameworks” (Heritage & Clayman, 2010, p. 17).

Applied CA follows the same general principles as pure CA; however, institutional settings impose special constraints on the interaction that are not necessarily present in ordinary conversational settings (Drew & Heritage, 1992; Heritage & Clayman, 2010). That is, the goals of ordinary conversations largely depend on the particular participants; therefore the goals are broad. In contrast, an interaction between a physician and patient has a specific goal that is oriented to the distinct sequential

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17 According to Heritage and Clayman (2010), institutional talk encompasses interactions in settings such as medical offices, classrooms, law courts, media venues, etc.
organization of turn allocation (i.e., repetitive cycles of questions and answers) that is preferred by this institutional setting (Heritage, 1997; Heritage & Clayman, 2010; ten Have, 2007). That is, the patient has a medical need and the physician works to understand that need (via various medical procedures and questioning) and to find an applicable solution. This orientation constrains the type of talk to that which will assist in completing the business at hand and which fits into the pre-determined framework and procedures of this specific institutional context. Results from CA research can illustrate the “relevance of particular interactional practices...and introduce new potentials for institutional reflexivity and organizational change” (Heritage & Clayman, 2010, p. 281).

Even though pure and applied CA treat context in different ways (i.e., context in pure CA is situated in the immediate talk between the speakers; context in applied CA considers both the immediate context and the context of the institutional setting), applied CA is deemed a valuable addition to CA research as long as it is faithful to the core analytic procedures of pure CA. The best way to remain faithful to the pure CA approach, when analyzing institutional interactional data, is to adhere to the specific verification issues of reliability, validity and generalizability (Beach, 2009) and to follow the general analytic strategy set out by pure CA as previously described (Heritage, 1997).

**Reliability**

In a conventional sense, reliability relates to the repeatability of the findings or the “repetition of concepts or meanings” (Wood & Kroger, 2000, p. 164) within the present data set and subsequent data sets over time. According to Hopper (1988), reliability in CA is achieved via exemplars of a claim from naturally occurring data. Exemplars from naturally occurring interactions are akin to “replications of experimental findings”
Hopper (1988) advocates for “real life” (Hopper, 1988, p. 53) (i.e., naturally occurring) exemplars over fictitious exemplars because recorded, naturally occurring interactions illustrate empirically grounded exemplars of sequences of talk in which people are actually discussing particular topics. In contrast, fictitious exemplars are constructed to illustrate extreme displays of the ways in which speech could function in various situations if speech could be predicted. Hopper states that recorded, naturally occurring exemplars provide “strong evidence” (Hopper, 1988, p. 53) for the reliability of the findings because exemplars are the actual occurrences of interactions with the “precise vocal and temporal details” (Hopper, 1988, p. 53) preserved, which can be checked for accuracy against the original recordings.

Validity

In a conventional sense, validity relates to the production of empirical findings that correspond as closely as possible to phenomena in their natural setting, independent of a researcher’s perceptions or beliefs about the phenomena (Wood & Kroger, 2000). Validity in CA is demonstrated by the “convergence between the researchers’ and participants’ perspectives. A phenomenon disclosed by a researcher must be a phenomenon to the participants” (Orletti, 1989, p. 76). The empirical findings in CA research are grounded within the recordings of naturally occurring, real time interactions and are illustrated through excerpts of detailed transcripts of the talk (Beach, 2009). The data are not “idealized, hypothetically derived, self-reported, and/or reconstructed choices and actions ‘driven’ by participants’ motives, needs, or other observer imposed phenomena” (Beach, 2009, p. 36). Validity of a researcher’s interpretation is tested by “tracking how the participants themselves make sense of their talk and comparing
exemplars against other exemplars” (Gale, 1989 as cited in Ratliff, 1992, p. 8). Validity is exemplified in next-turn proof procedures (Schegloff, 1991): the meaning of a speaker’s utterance can be found in the recipient’s very next utterance. That is, the analyst can examine the recipient’s utterance for confirmation of the analyst’s understanding of the speaker’s utterance, in the same way in which the speaker examines the recipient’s utterance for confirmation of the recipient’s understanding of the speaker’s utterance. For example, for an analyst to claim that the action accomplished by a speaker in an utterance is an insult, the analyst would need to show that the recipient treats the utterance as such.

According to Beach (2009), CA is a science that discovers and verifies the social organization of everyday life.

**Generalizability**

CA analysis of single cases and collections of specific phenomena provide a grounded basis for “developing generalizable descriptions of communication phenomena” (Beach, 2009, p. 36). Through the process of constant comparison of new data with that of existing analyses, CA researchers are able to “examine how larger collections of instances reflect generalized actions and patterns across diverse settings, speakers, topics, and cultures” (Beach, 2009, p. 36). According to Beach (2009),

The recurrence of communication events, balanced with how actions are determined to be relevant and significant, can be examined to determine whether and how same, similar, or deviant patterns of interaction occur across a wide array of data. Working simultaneously with single cases, and collections, can yield warrantable claims (rather than under-specified assumptions) about social order. (Beach, 2009, p. 36)
Analytic Resources

CA does not use or produce analytic coding schemes\(^{18}\) (Sidnell, 2010; Wood & Kroger, 2000). Rather, CA researchers access empirically grounded analytic concepts, which are based on observations, as resources that suggest what kinds of phenomena to look for and the ways in which those phenomena can be interpreted.

Analysis of the data for this dissertation involved using various CA analytic resources\(^{19}\). Some of the analytic resources were described in Chapter 1 (e.g., and-prefaced questions [Heritage & Sorjonen, 1994; routine checklists [Stivers & Heritage, 2001]; four dimensions of physicians’ question design [Boyd & Heritage, 2006; Heritage, 2010]). This section provides explanations of other main CA analytic resources.

**Turn-taking organization.** Turn-taking organization involves one person talking at a time with a minimal gap or overlap before speaker change (Heritage, 1997). Turn-taking assists participants to fine-tune and actively adapt the talk to co-construct a continuous interactional achievement. In the analysis of interaction, emphasis should be placed on how, if at all, participants display a shared normative orientation in their turn-taking that could be attributed to the sequential context. This can be achieved by determining and marking all the transition relevance places (TRPs: “a moment in the turn-at-talking in which that turn might be possibly complete and another speaker might take over;” ten Have, 2007, p. 219) at the end of any turn constructional units (TCUs: “the part of an utterance that might be a complete turn, after which another speaker might take over,” ten Have, 2007, p. 219; see also Heritage, 1997).

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\(^{18}\) ‘Analytic coding schemes’ in this instance refers to quantitative coding. It should be noted that this statement oversimplifies the issue of coding in that there are many types of coding (e.g., transcription guides are a type of coding scheme).

\(^{19}\) Abbreviated descriptions of all the analytic tools used in this research are provided in Appendix A: Glossary.
Overall structural organization of the interaction. After marking the TRPs and TCUs, the next step would be to construct an overall map of the interaction with an emphasis on its typical phases or sections (e.g., beginning, middle, end, transitions between topics) (Heritage, 1997). The map should not be seen as a fixed analytic framework into which future data are slotted, but as an evolving process to which the participants orient when organizing their talk.

Sequential organization. If there is a particular segment of the interaction that is of interest, the next step would be to isolate that entire segment and begin analyzing its sequential organization (i.e., “ordered progression of turns, often based on an adjacency pair”; [see below] ten Have, 2007, p. 219). This involves looking at how specific courses of discursive action are initiated and progressed, how different action opportunities begin and how they are suppressed, encouraged or closed (Heritage, 1997). If the entire interaction is of interest, it is best to begin with the first turn-sequence and systematically work through the interaction analyzing turn-taking and adjacency pairs throughout.

Turn design. Turn design has two components: the action the talk in a turn is designed to perform (e.g., gain information, inform, persuade) and the means that were selected by a participant to perform that action (e.g., a physician asks a closed-ended question to gain information; the patient expands an answer to a closed-ended question to introduce another topic) (Heritage & Clayman, 2010). Turn design contributes to sequential organization because the design of each turn can make relevant a particular type of action (e.g., a question by the first speaker makes relevant an answer by the second speaker). In turn, sequential organization “contributes to the phases of interaction which make up its overall structural organization” (Heritage & Clayman, 2010, p. 50).
**Repair organization.** Analysis of repair organization involves examining “various kinds of trouble in the interaction’s progress such as problems of (mis)hearing or understanding” (ten Have, 2007, p. 133; see also Schegloff, 2007). Often the trouble source creates an urgency that can lead to “a postponement or abandonment of the projected next action” (ten Have, 2007, p. 133). There are several ways in which a repair can be recognized and performed. For example, in self-initiated self-repair the repair is initiated and carried out by the speaker of the repairable (the trouble source) by halting or restarting the utterance to reword the repairable as a means of clarification.20

**Adjacency pairs (APs).** The basic features of an AP and its mode of operation are (Schegloff, 2007):

- Consists of two turns;
- Has two speakers;
- The turns are adjacently placed (i.e., one turn after another);
- The two turns are ordered in relation to each other in two ways. First, they consist of a first pair part (FPP) and a second pair part (SPP) and the two parts must be related to each other (i.e., the SPP must be the proper type of follow-up to the FPP). For example, with a question-answer AP (Q/A-AP) the question is the FPP because it initiates some exchange between the interactants. The selected respondent’s answer is the proper SPP when it is appropriately responsive to the discursive action of FPP. That is, “One o’clock” is a proper SPP to the question “What time is it?” In contrast, “No thanks” is not a proper SPP to this question, but would be a proper SPP to the question “Would you like a glass of milk?”

20 Other forms of repair include other-initiated self repair, self-initiated other repair and other-initiated other repair. See Schegloff (2007) and Sidnell (2010) for more details.
Second, APs are ordered into “pair types” (Schegloff, 2007, p. 14). That is, FPPs can be identified as particular types (e.g., questions, offers, greetings, requests) and each type of FPP has a corresponding SPP type. Same pair types include such APs as questions and answers, offers and acceptances or declinings, greetings and greetings, and requests and grantings or rejections. Non-same-pair types would be such instances as responding to a question with a greeting or responding to a greeting with a rejection. Same pair types aid in the continuity and the progressivity of the talk because the talk is able to move uninterrupted from some element, such as a question, to a hearably next element, an answer. If some utterance or sound interferes with the continuity of a same pair type, “it will be heard as qualifying the progressivity of the talk, and will be examined for its import, for what understanding should be accorded it” (Schegloff, 2007, p. 15).

**Answers, confirmations and responses.** Raymond (2010) uses the term “answer” (in quotation marks) to describe respondents’ replies to questions to which the questioners do not know the desired information (i.e., yes/no interrogatives [YNIs]). The use of YNIs makes relevant “answers” (also referred to as affirmations). Questioners use yes/no declarative questions (YNDs) as a way of making assertions or claims about matters when they assume to know about the matter, but would like to have their assumptions validated. The use of YNDs makes relevant confirmations from respondents. Raymond uses the term *responses* to describe respondents’ replies that are not directly relevant to the questioners’ enquiry. For the purposes of this dissertation, I will use the term *answer* (no quotation marks) in the general sense to describe information provided by the patient that is directly relevant to the physicians’ questions (i.e., “answers” or
[dis]affirmations to YNIs, [dis]confirmations to YNDs, relevant information to WH-Qs and selection of one of the proffered choices in ALT-Qs). When the information provided by the patient is not directly relevant to the physicians’ questions, I will use the term response.

**Type conformity.** As discussed previously (see Chapter 1), type-conforming answers are those made relevant by questions (Boyd & Heritage, 2006; Raymond, 2003; Schegloff, 2007). For YNIs and YNDs, the type-conforming answer is the word yes (or an equivalent token) or the word no (or an equivalent token). For WH-Qs (i.e., who, what, where, when, why, and how questions), the type-conforming answer is the information made relevant by the type of WH-Q (e.g., the name of a person for a who question). For ALT-Qs, the type-conforming answer is choosing one of the provided options.

**Preferred and dispreferred answers.** Preference is generally a bias toward a particular type of answer to the FPP of an AP (Schegloff, 2007). For example, an invitation prefers an acceptance and a request prefers a granting. As previously noted (see Chapter 1), questions may be designed to favour, prefer or suggest an expectation for one type of answer or one specific answer over another (Boyd & Heritage, 2006; Raymond, 2003). There are two main types of preference. First, there is a preference for a type-conforming answer over a non-type-conforming answer. Answers that are not type-conforming are dispreferred because they reject the agenda-setting function of the question. Second, grammatical design and polarity can influence the preference for a particular answer to a YNI or YND question. For example, words such as any, ever, at all have a negative polarity; thus, they prefer a no-type answer.
Agenda-transformative responses. Agenda-transformative responses work to transform the question’s focus, bias or presuppositions, and in effect to reject the design of the question (Stivers & Hayashi, 2010). The degree to which a respondent resists the agenda of a speaker’s question can be placed on a continuum from least to most resistant, depending on what the respondent does to the agenda of the question. For example, a response conveys a high degree of resistance when it is not relevant to the topic of the question (Stivers & Hayashi, 2010).

Alignment. Alignment is an action produced by a recipient of a speaker’s utterance that acknowledges the information the speaker provides and that supports the progress of the sequence of talk (Gill et al., 2009; Steensig & Larsen, 2008; Stivers, 2008). The recipient of the speaker’s utterance can enact alignment through vocal continuers such as uh huh, mm hm, yeah (Gill et al., 2009; Stivers, 2008) and laughter or laugh particles delivered at an appropriate point in the speaker’s turn-at-talk (Gill et al., 2001). These enactments of alignment treat the speaker’s turn as still in progress and communicate to the speaker that he/she has the floor until the speaker’s turn-at-talk is complete (Gill et al., 2001; Gill et al., 2009; Stivers, 2008). In contrast, disalignment is an action produced by a recipient that does not support the progress of the sequence of talk (Maynard & Hudak, 2008; Sidnell, 2007; Stivers, 2008). The recipient can enact disalignment through (a) declining to display acknowledgement of the information the speaker provides with prolonged silences or minimal responses such as mm (Maynard & Hudak, 2008); (b) laughter delivered at an inappropriate time in the speaker’s talk (Sidnell, 2007); and (c) competing for the floor to talk (e.g., changing the subject before the speaker has completed his or her turn).
Affiliation. Examination of affiliation or disaffiliation is central to the analysis of the sequential organization of interactions in much of the CA research (e.g., Emmertsen & Heinemann, 2010; Jones, 2001; Steensig & Drew, 2008; Stivers, 2008). In many articles, (dis)affiliation “is used more or less synonymously with terms like ‘(dis)alignment’, ‘(dis)agreement’ and even ‘(dis)preference’” (Steensig & Drew, 2008, p. 9). Affiliation is an action produced by a recipient of a speaker’s talk that demonstrates to the teller that the recipient has access to, and understands, the speaker’s stance and that the recipient endorses and supports the speaker’s perspective (Pillet-Shore, 2006; Ruusuvuori, 2007; Steensig & Drew, 2008; Stivers, 2008). Enactment of affiliation by the respondent can be achieved by: (a) endorsing assessments given at the end of the speaker’s turn (e.g., “That’s great.” “I understand what you’re saying”; see Ruusuvuori, 2007; Stivers, 2008); (b) claims or displays of like knowledge by recounting a similar situation (Ruusuvuori, 2007); and (c) reciprocal laughter (Pillet-Shore, 2006). According to Stivers (2008), head nodding is a vehicle for demonstrating preliminary affiliation. Research conducted by Stivers found that mid-telling head nods during face-to-face interactions demonstrate to the speaker that the recipient has access to the speaker’s reported event and that the recipient endorses the telling up to that point. One advantage of mid-telling head nods is that this action does not intrude into or derail the telling. According to Stivers (2008), “nods are carefully calibrated to the mid-telling environment and help convey that tellings are on their way to preferred affiliative uptake at story completion” (Stivers, 2008, p. 52). Actions that display the recipient’s disaffiliation include: (a) neutral acknowledgements such as *mhm* with falling intonation (Ruusuvuori, 2007); (b) assessments that are normally given at the end of the telling given during the
telling (Stivers, 2008); (c) failure to participate in laughter at the end of the telling (Pillet-Shore, 2006); and (d) disaffiliative questions that perform such actions as challenge, reproach, complain, criticize, disagree, etc. (Steensig & Drew, 2008).

**Troubles telling and troubles resistance.** According to Jefferson (1988), “conversations in which people talk about their troubles” (Jefferson, 1988, p. 418) display troubles telling. Speakers display troubles resistance by minimizing troubles telling when discussing distressing events during everyday conversations. Heritage and Robinson (2006) examined troubles resistance in physician-patient interactions. They found that one way for a patient to display troubles resistance was by demonstrating that he or she was “currently coping with their problems with fortitude” (Robinson, 2006, p. 76). Gill and Maynard (2006) also examined troubles resistance in their physician-patient data and they found that patients “play down the problem’s effect” (Gill & Maynard, 2006, p. 139) on them. Heritage and Maynard (2006) state that “patients may hedge their disclosure of troubles in the medical interview according to generic interactional and cultural practices that favor a stoic, ‘troubles-resistant,’ or ‘stiff-upper-lip’ stance” (Heritage & Maynard, 2006, p. 20).
Chapter 3: Method

Background

The data for this research were obtained from an outpatient Palliative and Supportive Care Clinic in Toronto, Canada. The Clinic’s goals include providing patients with: (a) pain management; (b) psychosocial and spiritual support; (c) ongoing and compassionate communication between the patient, family members and the palliative care team about the dying process; and (d) information and education about a variety of palliative care issues and available community resources. This Clinic is also a teaching facility that provides opportunities for post graduate medical residents and fellows on a palliative care rotation to interact with patients under the supervision of a physician specializing in palliative care.

Consultations with patients and family members may involve several healthcare professionals (e.g., a medical resident/fellow, the supervising physician, a pharmacist, a dietician, a social worker). To avoid overtiring the patient with a long visit and repeated questions, some healthcare professionals on the team may meet the patient (and any accompanying family or friends) together with the resident/fellow and/or the supervising physician (e.g., a pharmacist will attend the consultation to obtain information about the patient’s medications). Quality of care given to patients and family members is constantly monitored by the supervising physician (who is the Medical Director of the Clinic and a palliative care specialist). Medical residents/fellows on a palliative care rotation are evaluated on their communication skills when interacting with patients/family/caregivers, such as their ability to: (a) assess pain and symptoms effectively via a pain history\(^\text{21}\); (b)

\(^{21}\) Medical residents doing their palliative care rotation at the Clinic have been trained to use the PQRST mnemonic (discussed in Chapter 2) to assess patients’ experiences of physical pain.
evaluate symptom management plans; (c) identify and assess psychosocial and spiritual issues in end-of-life care; and (d) develop and implement a care plan to address in collaboration with other disciplines (see Appendix B for a complete list of criteria used to assess the residents’/fellows’ communication skills).

The medical residents/fellows are instructed by the supervising physician to obtain as much patient symptom information as possible during the initial history-taking phase of the consultation. To assist the physicians in assessing patients’ symptom information, every patient who attends the Clinic fills in the Edmonton Symptom Assessment Survey (ESAS; see Appendix C) prior to each consultation. The medical residents/fellows are instructed to compare patients’ answers on the most recent ESAS form to the previously completed forms as a way of evaluating the progression of patients’ experiences of the symptoms. Consultations can last for one to three hours, depending on the amount of information patients provide, the complexity of patients’ cases, and the type of care patients require at that visit. To ensure that patients receive the best possible care and that the medical residents/fellows receive appropriate training on their palliative care rotation, the consultations are conducted in five phases.

Phase 1: The medical resident/fellow is briefed by the supervising physician about a patient’s file.

Phase 2: The resident/fellow meets with the patient (and any accompanying people or healthcare professionals) for the initial physician-patient consultation (this interaction is observed by the supervising physician in another room via video-
recording). Upon completion of this phase, the resident/fellow excuses herself/himself and leaves the patient in the examining room.

Phase 3: The resident/fellow meets alone with the supervising physician in a room away from the patient to discuss the interaction in Phase 2 and the supervising physician provides the resident/fellow feedback on the consultation up to that point.

Phase 4: The supervising physician and the resident/fellow rejoin the patient in the examining room to complete the physician-patient consultation. Usually the resident/fellow completes the consultation. However, on some occasions, the supervising physician completes the consultation while the resident/fellow sits off to the side in the examining room and observes.

Phase 5: After the patient leaves, the supervising physician and the resident/fellow have a feedback session to discuss the resident’s/fellow’s performance during the consultation.

Video-recording of the resident/fellow-patient sessions is intended to be a regular part of the operation of the Clinic. The purpose of this practice is to provide residents/fellows with an opportunity to view the video recordings so they may assess their performance in sessions with patients and family members.

**Palliative Care Physician-Patient Interaction Research Project**

Ethical clearance was obtained from the University of Guelph Research Ethics Board, and the ethics board of the hospital that oversees the Clinic, for a research project to examine physician-patient interactions and supervisor feedback to residents/fellows. Consent procedures and data collection were conducted solely by the Clinic staff. Data
collection lasted for one year, beginning in March 2009. The data consisted of audio- and/or video-recordings of the five phases of the physician-patient consultation\(^\text{23}\). Specifically,

- Phase 1 (supervising physician-resident/fellow initial briefing) – audio-recorded
- Phase 2 (first part of resident/fellow-patient consultation) – video-recorded
- Phase 3 (midway feedback between supervising physician-resident/fellow) – audio-recorded
- Phase 4 (remainder of patient consultation with resident/fellow and supervising physician) – video-recorded
- Phase 5 (final feedback between supervising physician-resident/fellow) – audio-recorded.

The data corpus for this research project contains 15 physician-patient consultations with a total of seven patients (five patients had more than one consultation). The supervising physician (present at all consultations), nine medical residents and one medical fellow participated (four of the residents and the medical fellow conducted more than one consultation). At the time of data collection, all of the residents and the fellow had completed communication training and some courses on palliative care.

**Present Research**

**Data selection.** Generally, CA discourages beginning research with pre-selected questions inspired by the literature or previous research (ten Have, 2007). Rather, it is

\(^\text{23}\) Five consultations did not have all five phases recorded: two were missing a recording of the briefing, two were missing a recording of the final feedback, and one was missing both the briefing and final feedback recordings. Not all phases of the consultations were recorded as planned (e.g., Phases 2 and 4 were audio- instead of video-recorded; Phase 5 was video-recorded rather than audio-recorded). These changes occurred for various reasons (e.g., equipment malfunctions; the recording equipment being accidentally turned off or moved before the consultations were complete).
considered more appropriate to begin CA research with “unmotivated looking” (ten Have, 2007, p. 120). This involves the researcher exploring the data with an open mind as a means of “discovering phenomena rather than searching for instances of already identified and described phenomena or for some theoretically pre-formulated conceptualization of what the phenomena should look like” (ten Have, 2007, p. 120).

The initial purpose of this research was to use CA to explore the interactional dynamics of physician-patient palliative care consultations in a supportive/palliative care clinic. My intent was to understand how the actions and activities of physicians, patients and possibly family members are collaboratively achieved in real time, in the specific social, communicative and physical context of a palliative care clinic. The ultimate goal was to identify precisely some interactional communication practices of physicians and patients during consultations (e.g., physicians’ questions and patients’ answers) and “provide data-based analytic suggestions for or critiques of” (ten Have, 2007, p. 174) the ways in which the social order of these palliative care consultations is organized.

However, many conversation analysts understand that data are often collected with the intent of exploring a few basic concepts in a specific context as a means of making the social life in that context better in some way (ten Have, 2007). Since I did not know the exact content of the palliative care consultations prior to data collection, I proposed several possible general topics for examination with the expectation that the data would permit me to examine one or more of these topics, or some portion thereof:

- What are the communication practices of physicians and patients during the initial palliative care consultation?
• Which communication practices are effective and which are not, as indicated by the patient’s (and physician’s) actions, both verbal (e.g., misinterpretation of information, requests for clarification, vague responses) and non-verbal (e.g., intonation, gaze, posture)?

• How are plans for the course of palliative care constructed and negotiated by physicians and patients?

• Do palliative care physicians follow the communication practices recommended by communication specialists? Is there evidence for the effectiveness of those practices?

• How do palliative care physicians deliver and patients receive bad news?

• How do palliative patients display resistance to physicians’ suggestions and how do physicians manage such resistance?

Upon completion of data collection for the palliative care physician-patient interaction research project, I listened to the 15 consultations (all available phases) twice, making notes about possible topics of focus (e.g., talk about pain, nutrition, death, family support, test results, etc.; the ways in which history-taking was performed; the ways in which physicians solicited and patients disclosed subjective medical information; the ways in which empathy was enacted by physicians and possible missed opportunities for doing empathy). During the data collection period, only one patient had more than two consultations: this patient had five consultations. I chose to isolate the patient (P)’s consultations from the larger data corpus because his participation in five consultations and his meeting with five different medical residents (R1 – R5) and the supervising physician (SP) were unique in the data set. In addition, even though English is P’s second
language, he demonstrated a sophisticated working knowledge of the English language. This was not the case for many of the participants in the larger data corpus: some of the participants spoke little English. These patients had relatives translate for them and some participants noticeably struggled with speaking and understanding what the medical staff said to them in English.

The data set for this dissertation contained 191 minutes of video- and 25 minutes of audio-recorded physician-patient interactions (Phases 2 and 4). The remaining three phases (initial briefing and two feedback sessions) were used as background information when interpreting the results of this study. After transcribing verbatim P’s consultations\textsuperscript{24}, I listened to the audio-tape of the consultations while reading along with the transcripts many times (and in some cases I also watched a videotape\textsuperscript{25}), constantly making notes about possible topics of focus for the present research. Initially, I narrowed the focus to three general areas that were relevant to the mandate of the Clinic: pain management, psychosocial support and dying-implicative talk. I isolated sequences of talk for each main focus. I noticed that I had significantly more data than I would be able to analyze given the scope of the present study. Consequently, I chose to focus on one area of particular interest in palliative care: pain.

\textsuperscript{24} Transcriptions were completed using the data transcription software Transana (Version 2.42) and Adobe Audition (Version 1.5).
\textsuperscript{25} With regard to audio- and video-taping of Phases 2 and 4 of the five consultations, two of the consultations were audio-taped only and three consultations were audio- and video-taped. It should be noted that the placement of the camera allowed for a face-on view of the patient most of the time, but only a side view of the residents and a view of the back of the supervising physician’s head. As well, there are several times during the video-taping where the patient and/or the physician are not visible (e.g., during physical examinations, when the camera was accidentally moved). Due to having only three video files and not having full access to all of the participants’ facial features in those video files, I chose not to analyze the participants’ gaze and gestures.
Initially, I isolated all the talk relevant to pain in P’s five consultations. The pain talk was grouped into two main topics: talk about P’s experiences of physical pain and talk about pain medication. Although these topics are not mutually exclusive, in most cases there was a natural separation between these two areas of talk. I chose to focus on the talk about P’s experiences of physical pain as this was the area that involved more talk from P; talk about pain medication usually involved the physician discussing medication dosage and side effects while P listened, asking few questions. There were 28 sequences of talk about P’s experiences of physical pain (see Appendix D). These sequences were further transcribed using the fine-grained transcription notation developed by Jefferson (1984; see Appendix E). Using CA, I analysed the sequential organization of the 28 sequences of talk. This resulted in a large number of analyses. I narrowed further the focus of the present research to the physicians’ use of questions to assess P’s physical pain and P’s next turn responses to the physician’s questions. As well, I conducted an inductive analysis of the physicians’ questions and P’s next turn responses to determine the ways in which various aspects of P’s physical pain were being assessed (e.g., quality, site, intensity).

The patient. The patient was 46 years old at the time of data collection. His primary cancer was lung, which metastasized resulting in several tumours in his pelvic area. He spoke four languages fluently. He obtained a professional degree in his native country prior to immigrating to Canada and after immigrating he retrained as a tradesman. He was working in his Canadian-trained field when he was diagnosed with

26 Consistent with Saunders’ (2001) concept of “total pain,” P’s talk about his experiences of pain transcended several different general areas (e.g., physical, social, cultural). Although I understand that pain is a multi-faceted construct, for the purposes of this research I analyze only P’s talk about his physical pain.
cancer. At the time of the recorded consultations he was not working. He was divorced and had one son who was two years old at the time of the first recorded consultation. P always attended his consultants alone (i.e., without a family member or friend).

P was initially SP’s patient and became a patient of the Clinic soon after it opened. Consequently, the first recorded consultation with P is not his first palliative care consultation. During the one-year time period of the recorded consultations P received some palliative radiation treatments. These treatments were intended to help alleviate some of his pain, not to cure his cancer. As well, during the time period of the last two consultations he participated in a drug-testing study for chemotherapy in pill form at a hospital in Toronto. This experimental drug therapy was another means of managing his pain.
Chapter 4: Assessing Physical Pain I – Existence and Aspects

In Canada, physical pain is the most common reason people seek medical care (Canadian Hemophilia Society, 2011). In the United States, physical pain is one of the most common reasons for seeking medical care and it is frequently discussed during medical visits (Haskard-Zolnierek, 2012). In 1995, pain was coined the fifth vital sign (Canadian Hemophilia Society, 2011). Several organizations in Canada and the United States (e.g., American Pain Society, Canadian Cancer Society, Canadian Hemophilia Society, International Association for the Study of Pain, Joint Commission on Accreditation of Healthcare Organizations, US Veterans Administration) require that pain be documented as the fifth vital sign (along with pulse rate, respiration rate, blood pressure, and core temperature) (see Canadian Hemophilia Society, 2011). These organizations claim that all patients have a right to relief from pain.

Physician-patient communication about physical pain can be challenging for both parties (Haskard-Zolnierek, 2012; Perron & Schonwetter, 2001). That is, patients may become “frustrated by their physicians’ limited understanding of their experience” (Haskard-Zolnierek, 2012, p. 33) and physicians may find it challenging to ascertain the nature of patients’ physical pain (Haskard-Zolnierek, 2012; Perron & Schonwetter, 2001). According to recent survey research involving oncologists regarding the assessment and management of cancer pain, one of the most significant barriers to managing patients’ physical pain is “poor pain assessment” (Breuer, Fleishman, Cruciani, & Portenoy, 2011, p. 6).

Physical pain is a complex construct that involves several different aspects or components (Perron & Schonwetter, 2001). A patient’s physical pain can be related to
different etiologies, such as the primary life-limiting illness itself (e.g., cancer), the treatments for the illness (e.g., chemotherapy or surgery), and/or a chronic underlying condition such as osteoarthritis (Perron & Schonwetter, 2001). Factors such as the diversity of sensations of physical pain (e.g., stabbing, throbbing, sharp, aching, burning) and the multiplicity of pain locations also contribute to the challenge physicians face when they assess patients’ physical pain. Despite the significant frequency of patients’ talk to physicians about physical pain, there is relatively little research examining physician-patient communication regarding patients’ experiences of pain (Haskard-Zolnierek, 2012).

My analysis of the physicians’ enquiries about the various aspects of P’s experiences of physical pain, and of P’s answers relevant to the aspects of pain, was conducted inductively. That is, I identified the obvious or explicit aspect or aspects addressed in each of the 53 physicians’ questions about physical pain and in P’s answers and grouped the questions according to the aspect or aspects enquired about. On some occasions, the aspect enquired about was not explicit so I adopted Geertz’s (1983) CA-compatible interpretative anthropological view of the “experience-near concept”27 (Geertz, 1983, p. 57). According to Geertz,

An experience-near concept is, roughly, one that someone – a patient, a subject...might himself naturally and effortlessly use to define what he or his fellows see, feel, think, imagine, and so on, and which he would readily understand when similarly applied by others. (Geertz, 1983, p. 57)

Using Geertz’s (1983) experience-near approach grounded the aspects of pain enquired about in the data because I stayed recognizably close to the participants’ orientations and

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27 Geertz borrowed the concept of experience-near from Heinz Kohut (Geertz, 1983).
actions, rather than fitting the participants’ talk into a pre-determined coding scheme (e.g., the PQRST mnemonic). Three main groups of questions were identified: questions about the existence of pain (some of which refer to specific aspects of pain – see Table 1), non-specific questions about pain (see Table 2) and questions about specific aspects of pain (see Table 3). Specific aspects of pain involved 10 sub-groups: management/control, effects of treatment, consequences of pain, quality, frequency, site, severity, new, time and occasion.
### Table 1: Existence of Pain

<table>
<thead>
<tr>
<th>Excerpt #²⁸/ Sequence #²⁹</th>
<th>Question</th>
<th>Qualification (if any)</th>
<th>Answer</th>
<th>Answer Compared with Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>28/11</td>
<td>Does it- it’s not painful.</td>
<td></td>
<td>(0.7) Not painful: ah:: but it is different in some (respect). MAY BE A BIT More painful if you:: something like do something like this?, ah</td>
<td>Plus severity, occasion and site (indicated by thumping his fists on his thighs)</td>
</tr>
<tr>
<td>18/23</td>
<td>Any pains?</td>
<td></td>
<td>No (0.4) not right now.</td>
<td>Plus time</td>
</tr>
<tr>
<td>12/19</td>
<td>U:::m: (0.4) pt (0.2) an:::d (2.3) are you-do you have any pain?</td>
<td></td>
<td>(0.9) Ah::: (0.3) y:eah:: I have some pain ah:: yeah: usually in my pelvis.</td>
<td>Plus site</td>
</tr>
<tr>
<td>3/7</td>
<td>Has there been any n::ew pain that’s come up (0.3) apart from the- your regular [pain].</td>
<td>Qualified with new</td>
<td>[No.] I had enough.</td>
<td>Plus non-specific</td>
</tr>
<tr>
<td>19/24</td>
<td>Any any new pains in the back here?</td>
<td>Qualified with new and site</td>
<td>(0.2) New? (0.2) N::o: no new.</td>
<td></td>
</tr>
<tr>
<td>29/11</td>
<td>But not just normal touch.</td>
<td>Qualified with occasion</td>
<td>(0.3) Not normal yeah. (0.7) no</td>
<td></td>
</tr>
<tr>
<td>22b/7</td>
<td>No chest pain or palpitations.</td>
<td>Qualified with site</td>
<td>(0.5) No.</td>
<td></td>
</tr>
<tr>
<td>9/17</td>
<td>In here?</td>
<td>Qualified with site</td>
<td>(0.5) No.</td>
<td></td>
</tr>
<tr>
<td>8/17</td>
<td>Is there any pain in your back?, (. ) right now?</td>
<td>Qualified with site and time</td>
<td>(0.7) No.</td>
<td></td>
</tr>
</tbody>
</table>

²⁸ The excerpt number is the number that was assigned to each question/answer adjacency pair when it was initially grouped into a question type (see Table 2 – Chapter 5).
²⁹ Appendix D contains the 28 sequences of talk about P’s experiences of pain. The sequence number allows the reader to locate the excerpt in the larger sequence of talk.
# Table 2: Non-Specific Questions About Pain

<table>
<thead>
<tr>
<th>Excerpt #/Sequence #</th>
<th>Question</th>
<th>Answer</th>
<th>Answer Compared with Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>35/22</td>
<td>Weakness an[d pain]</td>
<td>[more or less] the same</td>
<td></td>
</tr>
<tr>
<td>11/18</td>
<td>Any changes?</td>
<td>[No].</td>
<td></td>
</tr>
<tr>
<td>20/1</td>
<td>In terms of the pain?, there’s no change.</td>
<td>(. ) U::m (. ) I don’t zink so no no it is not worse.</td>
<td>Plus severity</td>
</tr>
<tr>
<td>34/22</td>
<td>Your pain is the same.</td>
<td>(0.2) The same</td>
<td></td>
</tr>
<tr>
<td>23/9</td>
<td>And your pain is:: (1.0) m:: (0.2) about the same it sounds like.</td>
<td>(0.9) This- (0.2) now it is different.</td>
<td>Plus time</td>
</tr>
<tr>
<td>1/3</td>
<td>U::m::: so couple things I wanna know is how is your pain.</td>
<td>(1.3) U:m (2.0) I still have pain. (0.5) Yeah. (1.5) U::m (0.3) but I having better that it’s stopped growing in my::: ah::: ah: my pelvis (0.2) Cuz I had radiation.</td>
<td>Plus site and treatment</td>
</tr>
<tr>
<td>39/9</td>
<td>Tell me how your pain’s different.</td>
<td>(1.1) I:-I:-it’s Pain is always ah something like present but it is something like different. I don’t know how. But i- ah i- it was different before?</td>
<td>Plus time</td>
</tr>
<tr>
<td>42a/15</td>
<td>What is the pain?</td>
<td>(1.2) What?</td>
<td></td>
</tr>
<tr>
<td>38/3</td>
<td>Do you have any specific issues that you wanted to bring up?, with regards to your pain?, (0.5) this week.</td>
<td>(1.5) M::uah:: it hasn’t changed a lot (. ) m:: (. ) m:: (0.2) in the last hm</td>
<td>No answer</td>
</tr>
<tr>
<td>Excerpt #/Sequence #</td>
<td>Question</td>
<td>Aspect of Pain</td>
<td>Answer</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>33/20</td>
<td>So it sounds like it’s (0.2) it the pain is:: (0.5) is well controlled.</td>
<td>Management/Control</td>
<td>(.) M-more or less yeah it’s okay yeah.</td>
</tr>
<tr>
<td>6/13</td>
<td>Or could it be better?</td>
<td></td>
<td>(1.0) I think very yeah it’s okay.</td>
</tr>
<tr>
<td>15/19</td>
<td>Does anything make it better?</td>
<td></td>
<td>(1.1) U::m (1.9) no I don’t need ah:: I think anything for this.</td>
</tr>
<tr>
<td>16/20</td>
<td>Could it be better controlled?</td>
<td></td>
<td>(1.0) I don’t want to take more,</td>
</tr>
<tr>
<td>37/6</td>
<td>And how is that helping your pain?</td>
<td>Effects of Treatment</td>
<td>(0.7) Ah it’s ah yeah (0.2) it’s:: more or less okay yeah.</td>
</tr>
<tr>
<td>51/18</td>
<td>Is:: ah:: is:: that [bothersome::e &gt;after you stop it&lt;]</td>
<td></td>
<td>ah::: more [or less]</td>
</tr>
<tr>
<td>42b/12</td>
<td>What does worked (0.2) mean for you. (0.6) That the [radiation]</td>
<td></td>
<td>[Ah:: it's]:::stopped (0.6) stopped pressing my nerves.</td>
</tr>
<tr>
<td>40/4</td>
<td>How is your::: (.) pain after this last chemo session?</td>
<td></td>
<td>(1.2) It hasn’t changed ah:: (0.7) I dunno. (0.2) With this new chemo I: I usually ah (.) I:-I have more pain::, especially in my pelvis.</td>
</tr>
<tr>
<td>2/6</td>
<td>So when you take the medication (0.3) do you have relief?</td>
<td></td>
<td>(1.2) Hm: (0.4) Yeah. (0.5) It’s:: (0.9) Yeah (0.4) I have relief</td>
</tr>
<tr>
<td>26/10</td>
<td>Your everyday life is less affected by the pain?</td>
<td>Consequences of Pain</td>
<td>(1.0) Right now it’s less.</td>
</tr>
<tr>
<td>7/16</td>
<td>Is any activity that you are avoiding to do because of the pain?</td>
<td></td>
<td>(1.1) Ah:: (0.4) I am avoid-avoiding may be (0.3) sitting for long (h) ti(h)me</td>
</tr>
<tr>
<td>Excerpt #/ Sequence #</td>
<td>Question</td>
<td>Aspect of Pain</td>
<td>Answer</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>17/21</td>
<td>An::d do you ever wake from (0.5) u:m: (..) wake in the middle of the night because of pain?</td>
<td>Consequences of Pain</td>
<td>(1.0) Mm::: no.</td>
</tr>
<tr>
<td>27/10</td>
<td>So you’re able ta (0.2) ta do activities that may be you weren’t able ta do before.</td>
<td></td>
<td>(1.0) Yeah-yay-ah:-um yeah.</td>
</tr>
<tr>
<td>24/9</td>
<td>It’s just there.</td>
<td>Quality</td>
<td>(0.4) I-ju-it’s there yeah</td>
</tr>
<tr>
<td>46/9</td>
<td>And is it an achy pain?</td>
<td></td>
<td>(0.2)</td>
</tr>
<tr>
<td>14/19</td>
<td>U::m::: (0.2) do you feel it occasionally you said.</td>
<td>Frequency</td>
<td>(.) Occasionally.</td>
</tr>
<tr>
<td>46/9</td>
<td>Is i:t (0.2) something that (0.5) is kind of always (0.2) always there?, Does it come and go?:?,</td>
<td></td>
<td>(1.1) Mine is always there.</td>
</tr>
<tr>
<td>30/15</td>
<td>Okay it’s both legs::?:</td>
<td>Site</td>
<td>(0.5) B-both legs but more (.) more the right one.</td>
</tr>
<tr>
<td>43/15</td>
<td>Where. What [part of] yer body</td>
<td></td>
<td>(1.2) What? [Where?] =Ah (0.3) it’s usually in my pelvis and ah:: yeah it’s usually in my pelvis. (0.8) So I have some like unusual feelin from the outer side of my legs and my feet.</td>
</tr>
<tr>
<td>49/15</td>
<td>And from one to ten when ten is the worst pain so you (..) you describe that you were (0.4) having a tree. (0.2) Is that [correct]?</td>
<td>Severity</td>
<td>[Yeah] yeah.</td>
</tr>
<tr>
<td>13/19</td>
<td>Is that a new pain?</td>
<td>New</td>
<td>(0.7) Ah::: (1.3) may be it is not a new pain no. Because I have also tumour here.</td>
</tr>
<tr>
<td>Excerpt #/</td>
<td>Question</td>
<td>Aspect of Pain</td>
<td>Answer</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Excerpt #/</td>
<td></td>
<td>Question with more than one aspect</td>
<td></td>
</tr>
<tr>
<td>Sequence #</td>
<td></td>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>51/18</td>
<td>And how is the pain now:</td>
<td>Time</td>
<td>[Ah it’s more or less okay]</td>
</tr>
<tr>
<td>50/16</td>
<td>So: it seems that the- the- the day (0.3) the- the pain during the da::y has been stable. (0.4) Is that [correct]?</td>
<td>Time</td>
<td>(Y:eah::]ah: it’s it’s more or less &gt;yeah yeah&lt; stable even during the night. It’s stable [more or less].</td>
</tr>
<tr>
<td>41/9</td>
<td>And so Instead of the having the pa:in: pressing on your nerves what’s the pain feel like now?,</td>
<td>Time</td>
<td>(2.4) Now:ah ho-how i-it’s like PREsent ah-i-i it’s present.</td>
</tr>
<tr>
<td>5/13</td>
<td>Are you happy with where your pain control is now.</td>
<td>Time + Management/Control</td>
<td>(1.3) U::h:: (0.7)</td>
</tr>
<tr>
<td>25/10</td>
<td>So you feel like you’re-(0.2) better:: able tat a manage the pain now?</td>
<td>Time + Management/Control</td>
<td>(1.0)U::m:</td>
</tr>
<tr>
<td>36/19</td>
<td>When when when do you notice it.</td>
<td>Time or Occasion</td>
<td>(0.9) When?: I always notice it.</td>
</tr>
<tr>
<td>52/1</td>
<td>In FACT You ranked it as:: a little even bit better than the last time ar-around, &gt;do you think that that’s the truth?, &lt; or somewhere (hh)huh probably about the same.=</td>
<td>Time + Severity</td>
<td>=It could be yeah:::</td>
</tr>
<tr>
<td>54/5</td>
<td>When we look at your (0.3) your u:m: pt symptom assessment (. ) report (0.5) u::m (. ) your pain is constant. It was (0.2) two the last time, it’s two this time. (0.2) .hhh U::m: (1.0) but you (<em>) seemed &gt;to have&lt; (0.3) &lt;been: more&gt; aggressively showing (0.6) ah::: just the symptoms were (</em>) a-or may be more so there the last time. &gt;That could&lt; just be:: (_) how you were drawing but,</td>
<td>Time + Severity</td>
<td>(0.5) &gt;I-I-I&lt; just ah::: (1.1) I just (0.2) u::: (0.2) draw the area more or less i-i- it does[n’t me]an that i-it intensity. Yeah.</td>
</tr>
<tr>
<td>Excerpt #/Sequence #</td>
<td>Question</td>
<td>Question with more than one aspect</td>
<td>Answer</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>21/4</td>
<td>So it had gone up (0.3) at (0.2) the start of the session. =</td>
<td>Severity + Treatment</td>
<td>=Yeah.</td>
</tr>
<tr>
<td>53/4</td>
<td>&gt;And so&lt; your perception is that (0.4) the pain has been CONstant. It hasn’t (0.4) decreased or it hasn’t increased (0.2) in with this last session?=</td>
<td></td>
<td>=&gt;Yeah yeah it&lt; increased when: they began (the new) chemo?,</td>
</tr>
<tr>
<td>45/6</td>
<td>I mean- (0.4) does it get from like (1.2) does it ever get down to zero or do you always have (0.3) pain?</td>
<td>Severity + Frequency</td>
<td>(0.7) Ah:: (0.2) I have pain more when when I am sittin.</td>
</tr>
<tr>
<td>47/15</td>
<td>And when you say unusual is: it: is: more painful or is (0.3) feel differ[ent]?</td>
<td>Severity + Quality</td>
<td>[As in] feel different ah:: (0.2) not normal feelin, because here for example is everysing normal as it was before the cancer.</td>
</tr>
<tr>
<td>48/24</td>
<td>Where does it hurt the most in your back. (0.5) Or [in your pelvis].</td>
<td>Severity + Site</td>
<td>[In my back] it’s usually not. It’s like ah pelvis ah:: (0.2) more here from the right side.</td>
</tr>
<tr>
<td>32/19</td>
<td>It’s alwa- you always feel it there.</td>
<td>Site + Frequency</td>
<td>(0.2) Yeah:: sometimes yeah but ah::</td>
</tr>
</tbody>
</table>
Physicians’ Questions

Existence of Pain

All nine of the questions about the existence of pain are ‘no-pain’ questions in that they are designed for a ‘no-pain’ answer. That is, no pain is explicitly stated in the question and a preferred answer would indicate no pain (e.g., “Does it-it’s ((the pain)) not painful”; three of nine), or the questions are designed to prefer an answer that indicates that P does not have pain to report because of the inclusion of a negative polarity item\(^{30}\) (e.g., “Any pains?”; six of nine)\(^{31}\). There are no questions that are ‘pain’ questions in the sense that they prefer an answer indicating P has pain (e.g., Do you have pain?, which prefers a yes-type answer). No pain is enquired about in a general sense in three questions (Excerpts #28, #18 and #12). In six questions it is qualified with one or two specific aspect(s) of pain (i.e., new pain, site, occasion and time). No-pain questions are relatively infrequent in the data; their use during the physical examination (four of nine) is not unexpected given that this is usually accompanied by a set of standardized questions that includes such questions (i.e., the routine checklist) (see Stivers & Heritage, 2001). However, their use by the residents outside of the examination (five of the nine) is unexpected in that just prior to the consultations with P the residents were informed by SP that they were to assume that all patients attending the Clinic had physical pain. It should be noted that SP herself does not ask any no-pain questions.

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\(^{30}\) Preference structure of questions and negative polarity items are discussed in Chapters 2 and 5.

\(^{31}\) Although there is a distinction between no pain being included in the question and a question about pain that makes relevant an answer indicating no pain, for the purposes of this dissertation questions of this nature will be referred to generally as no-pain questions unless otherwise specified.
Non-Specific Questions About Aspects of Pain

The physicians ask nine questions that are non-specific\textsuperscript{32} with respect to aspects of pain. That is, the questions refer to pain in a general sense, devoid of any identifying aspects such as severity, quality or time. An advantage of asking non-specific questions about aspects of pain is that P is not limited to talking about his experience of pain from a particular standpoint (e.g., frequency, site). Rather, he is given the opportunity to talk about the features of his pain that are most salient to him. In three questions the physicians include a time aspect (i.e., #51 and #41 – “now”; #50 – “during the day”). The time aspect narrows the focus of P’s answer within the pre-determined time frame stated in the question.

Specific Aspects of Pain

Management/control. This aspect is specific to talk about the management/control of (or lack thereof) P’s physical pain. The physicians’ questions explicitly ask about pain control, and in some cases, implicitly ask about P’s level of satisfaction with his current pain management. For example, “Could it ((the pain)) be better controlled?” and “Or could it ((pain control)) be better?” explicitly ask P about his pain control and implicitly ask him to evaluate how satisfied he is with the physicians’ pain management plan. When the management/control aspect is paired with a time aspect (i.e., “now” in # 5 and #25), both components (explicit and implicit) are restricted to the present time.

\textsuperscript{32} The physicians’ non-specific questions identified in the present study are similar to the “non-focused questions” (Clemente, Lee, & Heritage, 2008, p. 1420) discussed in Clemente et al.’s research that examines children’s chronic pain in tertiary care. Clemente et al. (2008) define non-focused questions as those that “invite the addressee to talk about a topic while giving latitude as to how that talk would be framed” (p. 1420).
Effects of treatment. Effects of treatment refers to talk specific to P’s experience (or lack thereof) of physical pain in relation to some form of treatment. The physicians’ questions relevant to this aspect enquire about P’s reaction to pain medication (#37, #51 and #2), radiation (#42b) and chemotherapy treatments (#40). In Excerpts #21 and #53, effects of treatment is paired with severity of pain in questions that assess the pre- and post-radiation effects relevant to physical pain.

Consequences of pain. This aspect relates to descriptions of possible ways in which P’s physical pain may affect his life, and whether or not the pain prevents P from doing the actions and/or activities he wants to do. The physicians’ questions that pertain to this aspect prefer an answer indicating that P’s experience of pain has lessened, thereby allowing him to do activities he wants to do (#26, #7 and #27) or that his pain has not increased and it does not disturb his current routine (i.e., sleeping through the night - #17).

Quality. Quality refers to descriptions of what P’s pain feels like (e.g., “And is it an achy pain?” #46). In Excerpt #47, quality is paired with severity in a question concerning some specifics about P’s new experience of pain.

Frequency. This aspect relates to descriptions of how often P experiences pain. The physicians’ questions relevant to the frequency of P’s pain ranged on a continuum from not at all (“ever get down to zero”) to “occasionally” to “always.” In two questions frequency is paired with another aspect (#45 – severity; #32 – site).

Site. Site relates to talk about the location of P’s physical pain on his body. In two questions the physicians enquire about only the site of P’s pain (#30 and #43). In two questions, site is paired with one additional aspect (#48 severity & #32 frequency). Site
qualifies an enquiry about no pain in four questions (#22b, #9, #19 & #8); it is paired with one additional aspect in two of these (#19 new & #8 time). Site is the third most commonly paired aspect of pain (paired four times). Pairings of site with other aspects facilitates the physicians’ assessment of the possible progression of P’s cancer.

**Severity.** Severity refers to descriptions of the intensity of P’s experiences of pain (e.g., on a scale of one to ten, with ten being the most severe). Severity is enquired about on its own in only one question (#49). It is paired seven times with other aspects making it the most commonly paired aspect of pain enquired about (#52 and #54 – time; #21 and #53 – treatment; #45 – frequency; #47 – quality; and #48 – site). Pairing of severity with a range of other aspects of pain is consistent with SP’s instruction to the residents that they are looking to understand the “mechanisms of the pain because that’ll dictate the choice of medication.”

**New.** New refers to talk about P’s new experiences of pain, sometimes explicitly in relation to regular pain. The physician’s question pertaining to this aspect of pain (#13) explicitly enquires about whether or not P is experiencing a new pain. In Excerpt #3, the physician asks a no-pain question in which pain is qualified with new. In Excerpt #19, the physician also asks a no-pain question, but this time it is qualified with site. Enquiries about new pain (or lack thereof) facilitate the determination of disease progression.

**Time.** Time is a multi-dimensional aspect in that it can refer to a: (a) specific time period when P notices or experiences the pain (e.g., “during the day”); (b) comparison of the pain at one point in the past as compared to now (i.e., then and now); or (c) comparison of the pain before some action or activity as compared to after the action or activity (i.e., before and after). Physicians ask three questions in which time is the only
aspect (#51, #50 and #41). Otherwise, time is always paired with another aspect (#5 and #25 – management/control; #36 – as an alternative to occasion; #52 and #54 – severity and #8 in which time is paired with site to qualify a no-pain question). Time is the second most commonly paired aspect of pain in the physicians’ questions (paired six times). Pairing of time with a range of other aspects of pain aids the physicians in determining a timeline for the various aspects of pain.

**Occasion.** This aspect of pain relates to the action (e.g., “not just normal touch” #29) or activity (e.g., sitting) that is involved when P notices or feels more, less or no pain. Questions about an occasion of pain are either qualifying an enquiry of no pain (#19) or are offset against another aspect (#36 time). Occasion of pain is the least enquired about aspect of pain in the present data set (n=2).

**Congruence/Incongruence of Aspects of Pain in Answers/Responses**

P’s answers to the questions about the existence of pain that are not qualified (#28, #18, & #12) all involve P adding at least one aspect of pain. Specifically, P’s answers to two of the questions (#28 & #12) identifies painful areas of his body (i.e., legs [indicated by thumping his fists on his thighs] and pelvis) and his answer in #18 adds the aspect of time (“not right now”). Through qualification of his answer of no pain with a time element, P (a) explicitly indicates that at the current time he has no pain; (b) implicitly indicates that his experience of pain is variable, not stable; and (c) implicitly acknowledges the potential for future pain. In contrast, when the no-pain question is qualified with an aspect other than time, P’s answer is usually congruent or in line with the aspects enquired about (with the exception of Excerpt # 3 in which P adds the non-specific statement, “I had enough”).
Slightly fewer than half of P’s answers to the non-specific questions are congruent with the question (n=4 of 9); four answers contain at least one specific aspect and once P does not answer the question (instead he requests clarification of the question). Given that the non-specific questions afford P the opportunity to introduce the aspect or aspects of pain that are immediately relevant to him, it is interesting that in four instances he pitches his answers at the same level of generality as the question (e.g., in excerpt #34 P answers with “The same”; in excerpt #38 P states “it ((the pain)) hasn’t changed a lot”) and his answers that refer to time are otherwise rather general. The generality of P’s answer results in the physician having to work harder (i.e., ask follow-up questions about specific aspects of pain) in order to learn details about the ways in which P experiences his pain.

P’s answers are in line with, or congruent with, the aspect enquired about in the physicians’ questions for the single aspects of management/control, severity, new pain, frequency, site and time. However, when an additional aspect is included in the question pertaining to one of these aspects, P’s answer is not always entirely congruent with the aspects in the question. Specifically, in excerpts #5, #25 and #52 (time + management/control) P does not answer the questions; in excerpts #45 and #47 (severity plus time, frequency or quality) P leaves out one or more aspects and adds an aspect.

The majority of P’s answers to the questions on the single aspects of consequences of pain, effects of treatment, quality and time are congruent with the aspects of pain in the questions. When P’s answer is not congruent, he either adds an aspect (excerpts #40, #26 and #7) or he does not respond to the question (excerpt # 46).

The time aspect is paired with several other aspects in the physicians’ questions: site, management/control, severity, and occasion. For half of these questions, P’s answer
is congruent with both aspects in the question. In the rest of the instances, the aspect(s) of pain addressed in P’s answer is not completely congruent with the aspects in the question: three questions are not answered; one question is answered using only time. The exception to the finding that pairing is associated with some incongruency is when site is paired with another aspect (i.e., #48 – site + severity; #32 – site + frequency). P’s answer in these cases is congruent with both aspects in the question.

**Plurality of Physical Pain**

Many patients with life-limiting illness have comorbid pathologies that involve various types of pain and pain in multiple locations (Perron & Schonwetter, 2001). Adequate assessment of pain requires assessment of all of the patient’s experiences of pain. In addition to asking about specific aspects of pain, there are several ways for a physician to communicate to a patient an interest in learning about a patient’s various experiences of pain. For example, the physician can: (a) use such grammatical devices as the plural of pain (pains); (b) ask about pain in several specific areas of the patient’s body; (c) ask the patient to compare the experience of one pain versus another; or (d) ask the patient to compare the experience of a regular pain versus a new pain.

In this study, there are only two occasions when the physicians’ questions include the plural “pains” (“Any any new pains in the back here?” #19 and “Any pains?” #18). The physicians predominantly refer to P’s pain as singular (e.g., “In terms of the pain? there’s no change” #20; “How is your pain after this last chemo session?” #40). The physicians explore the various locations of P’s pain by asking him about specific areas of his body (e.g., pelvis, back, legs and with deictics such as “here” and “there”) when he states he has pain, and when his medical records indicate that he is likely to have pain.
because of the metastasized cancer. As well, the physicians ask P to compare his 
experiences of pain (e.g., “Where does it hurt the most in your back. Or in your pelvis” 
#48), and they ask him to compare possible new pain to regular pain (e.g., “Has there 
been any new pain that’s come up apart from the- your regular pain” #3).

There are no instances in P’s answers where he refers to his experience of pain in 
the plural. However, he talks about his pain in relation to specific areas of his body (e.g., 
pelvis, back, legs). As well, he compares his experience of pain in one area of his body to 
another (e.g., “Both legs but more more the right one” #30) and he compares his current 
experience of pain in relation to his experience prior to the cancer (e.g., “As in feel 
different ah not normal feelin, because here for example everything is normal as it was 
before the cancer” #47).

**Change-Implicative Talk in Aspects of Pain**

As discussed in Chapter 1, assessment of changes in patients’ experiences of 
chronic or previously treated physical pain is considered a vital component of pain 
management (Barnard & Gwyther, 2006; Bates, Bates, & Northway, 2002; Perron & 
Schonwetter, 2001). In this data set, questions that explicitly and implicitly enquire about 
changes in some aspect of P’s experiences of physical pain are pervasive throughout the 
question data. Examples of questions that ask explicitly about changes are, “So it ((the 
pain)) had gone up at the start of the ((chemo)) session” (#21) and “In terms of the pain?, 
there’s no change” (#20). Another tactic for enquiring explicitly about a lack of change in 
P’s pain is asking if the pain is “the same” or “constant.” Questions that ask explicitly 
about changes are mainly non-specific questions and questions pertaining to the aspects

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31 From this point forward change or lack thereof will be referred to generally as changes unless otherwise specified.
of management/control; effects of treatment; consequences of pain; frequency; the
combined aspects of time with management/control, occasion or severity; and the
combined aspects of severity with time, frequency or quality.

Implicit questions about changes in P’s physical pain are more common in these
data than explicit enquiries. Examples of questions that ask implicitly about changes are,
“Tell me how your pain’s different,” (#39) and “And how is that helping your pain?”
(#37). In these examples, a change in P’s experience of pain is implied in the first
question via asking about a general difference in his experience of pain and in the second
question via asking about a change specific to taking the medication (i.e., relieving his
pain). Other tactics that are used to implicitly enquire about changes in P’s experience of
pain are: (a) including a time element such as asking how his pain is “now;” (b) asking
about “new” pains without a comparison to a regular pain; (c) asking whether or not his
pain is controlled or if it could be better controlled; or (d) asking if the pain is or is not
impacting his life (e.g., “So you’re able tat a do activities that may be you weren’t able ta
do before.” #27).

In addition to the abovementioned tactics, questions that implicitly enquire about
changes often use various grammatical devices and lexical choices. For example, the
grammar used by the physicians when they design a question about P’s pain implies a
change in P’s experience of pain. This is demonstrated in the question “So when you take
the medication do you have relief?” (#2). The phrase “take the medication do you have
relief” communicates that there is the possibility that P’s pain might change for the better
when he takes the medication. Another device used is comparative grammatical structure,
such as “Your everyday is less affected by the pain” (#26). This question implies that the
effect of the pain on P’s everyday life is on a continuum of less to more. In “Do you feel it occasionally you said.” (#14) “occasionally” implies that P’s pain is not stable: it comes and goes.

The physicians’ lexical choice also works to imply changes in P’s experience of pain. For example, in “And how is your pain now?” (#51), “now” implies P’s pain may be different at the present time as compared with a point in the past. The tense used in the question can also imply change. For example, in “And from one to ten when ten is the worst pain so you describe that you were having a three. Is that correct?” (#49), the use of the past tense “were” implies that there is potential for change in P’s experience of pain.

P’s answers also explicitly and implicitly indicate changes in his physical experience of pain. Examples of explicit answers are, “Yeah yeah it increased when they began chemo?” (#53) and “I still have pain. Yeah. Um but I having better that it’s stopped growing in my ah ah my pelvis cuz I had radiation” (#1). An example of an implicit answer that indicates changes in his experience of pain is “I am avoid-avoiding may be sitting for long time” (#7). In this answer, the use of present continuous tense (“I am avoiding”) implies that his pain is variable. That is, at that time his experience of pain is at a level whereby he cannot sit for long periods of time, but this level of pain might have been different in the past and might be different in the future. P’s answer “Yeah I have relief” (#2) also implies a change in his experience of pain. That is, to have relief from pain implies that his level of pain was previously higher than it is at that time. Similarly, the answer that he feels pain “Occasionally” (#14) implies that the pain is not stable, that it comes and goes.
With regard to the prevalence of questions and answers that explicitly and implicitly enquire about changes versus lack of changes in some aspect of P’s experiences of pain, the physicians’ questions and P’s answers are more likely to be explicit when talking about lack of change in P’s pain and implicit when talking about change in P’s pain. An interesting feature of P’s answers about changes in his pain is that he tends to highlight changes for the better (e.g., “I having better that it stopped growing in my pelvis” #38; “It’s stopped pressing my nerves” #42b), lack of change (e.g., “New? No no new” #19; “I don’t think so no no it is not worse” #20; “more or less the same” #35), and he minimizes changes for the worse (e.g., “It hasn’t changed a lot” #38; “may be a bit more painful” #28). P’s answers display what Jefferson (1988) regards as “troubles resistance” (Jefferson, 1988, p. 415): the act of minimizing troubles when discussing distressing events. P’s reference to not having any new pains and his claims that his pain is “not worse,” “hasn’t changed a lot” and is possibly “a bit more painful” show P discursively (a) playing down the effects of the pain, (b) displaying stoicism, and (c) coping with the pain with fortitude (see Gill & Maynard, 2006; Heritage & Maynard, 2006; Robinson, 2006).34

**Multi-Dimensionality of Pain**

Pairing of the aspects of pain occurs in 13 of the 53 physicians’ questions. For example, quality appears alone in two questions and it is paired with severity in one question; site appears alone in four questions and it is paired with severity, frequency, new and time in four other questions; severity appears alone in one question and it is paired seven times (with time, treatment, frequency, quality and site); time appears alone three times and is paired six times with another aspect (site, management/control, management/control, management/control).

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34 A description of troubles resistance is in Chapter 2.
occasion and severity). The multi-dimensionality of pain also goes beyond pairing of the aspects. That is, it involves other layers of dimensions such as the various ways in which the plurality of pain is discussed, the explicit and implicit talk regarding the aspects, and the various ways in which changes in pain are incorporated in the talk.

Enquiries and answers relevant to the aspect of time particularly demonstrate multi-dimensionality, that is, temporality is woven in with the other aspects. For example, references to time such as “now,” “middle of the night,” “before,” and “during the day” subsume aspects such as consequences of pain, frequency, and occasion. Including a temporal feature in the talk regarding other aspects of pain builds in a sense of variability: the pain is not stable, it has the potential to change in various ways (e.g., whether it is present or not present, when it is present, how often it is present).

**Summary of Findings**

The physicians in this study explore and examine the complex nature of P’s experiences of physical pain. In this chapter, I performed an inductive analysis of the questions and answers in the data set. Further, the unmotivated looking of CA was combined with Geertz’s (1983) experience-near concept to ground the identified aspects of pain in the data. I determined that there are three main groups of physicians’ questions: existence of pain, non-specific questions about aspects of pain and specific aspects of pain (with 10 sub-groups: management/control, effects of treatment, consequences of pain, quality, frequency, site, severity, new, time and occasions).

The main findings for the question analysis are: (a) the residents in this research do not consistently assume P has pain even though they were instructed to do so by SP prior to the consultations (i.e., nine of the residents’ questions are designed for a no-pain
answer, with four occurring during the physical examination, which is not unexpected, and five occurring outside of the examination, which is unexpected); (b) the physicians ask non-specific questions in regards to aspects of pain that allow P to answer with information pertaining to any aspect of pain; however, in some instances P pitches his answer at the same level of generality as the question, which results in the physicians asking more questions; and (c) the physicians ask questions that explicitly enquire about pain control and implicitly ask P to evaluate his level of satisfaction with the physicians’ pain management plan.

The main findings for the answer analysis are: (a) P’s answers are in line with (or congruent with) the majority of the questions that ask about a single aspect of pain; and (b) the addition of another aspect of pain in a question often results in P either adding an aspect to his answer, not addressing the aspect enquired about in the question and addressing another aspect, or not responding to the question.

Another main point presented in this chapter is that although pain may appear in multiple locations and be of different types, physicians ask about P’s pain in the plural (i.e., pains) on only two occasions. However, the use of pain as a non count noun does not mean that physicians treat pain as undifferentiated. They demonstrate an understanding of the plurality of pain by asking P: (a) about his pain in several specific areas of his body, (b) to compare the experience of one pain versus another; and (c) to compare the experience of regular pain versus a new pain. In contrast, P does not refer to his pain in the plural. However, he: (a) talks about his pain in several different areas, (b) compares his experience of pain in one area of his body to another; and (c) compares his current experience of pain in relation to his experience prior to the cancer. It is not clear
that there is a meaningful difference between references to pain as a count or non count noun.

Change-implicative talk about the existence and aspects of P’s physical pain (i.e., explicit and implicit referrals to a change or lack thereof a change) are pervasive throughout the question data. Implicit enquiries are more common than explicit enquiries. The physicians use several tactics that implicitly ask about changes in P’s experiences of pain (e.g., including a time element such as “now”; asking about new pains; use of various grammar devices and lexical choices). The physicians’ questions and P’s answers are more likely to be explicit when talking about lack of change and implicit when talking about change in P’s pain. P’s answers regarding changes in his pain tended to highlight changes for the better and lack of change, and minimize changes for the worse. P’s answers might be characterized for the most part as displaying troubles resistance (see Jefferson, 1988).

Multi-dimensionality of aspects of pain is demonstrated in various ways. Specifically, aspects of pain are often paired. As well, there are layers of multi-dimensionality: the various ways in which the plurality of pain is discussed, explicit and implicit talk regarding the aspects, and the various ways in which changes are incorporated in the talk. Questions and answers involving the aspect of severity and time are particularly multi-dimensional. That is, severity and temporality are often woven in with the other aspects. Temporal variability oriented to in questions and answers is an important aspect that contributes to a sense of the complexity of pain as a subjective experience.
Chapter 5: Assessing Physical Pain II – Questions and Answers

In the 28 sequences of talk about P’s experiences of physical pain (see Appendix D) the physicians seek information from P (for the purposes of assessing his physical pain) in two ways:

- Questions in single-unit turns at talk (i.e., yes/no interrogatives [YNIs], yes/no declarative [YNDs], WH-questions [WH-Q] and alternative questions [ALT-Q]).
- Multi-unit turns at talk that contain questions (i.e., turns that involve more than one TCU, that contain at least one question seeking information, but that can include assessments, announcements and/or assertions).

Questions in Single-Unit Turns

The physicians asked a total of 49 questions, 44 of which were included in the analysis. The distribution of the questions that were analysed is as follows: 17 YNIs (38.6%), 15 YNDs (34.1%), 9 WH-Q (20.5%) and 3 ALT-Q (6.8%). For organizational purposes, the 44 questions in single-unit turns were initially grouped according to the type of question (i.e., YNIs and YNDs together, WH-Q, and ALT-Qs), and then by the type of answer provided by P (e.g., preferred answer/no delay, dispreferred answer). Further grouping was done within P’s answer groupings (e.g., preferred answer with delay – type conforming). Table 2 presents the groupings.

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35 Analysis of the 28 sequences of talk found that three sequences were initiated by P and those three excerpts do not contain any physical pain assessments (i.e., questions) by the physicians. See Appendix D.
36 Five of the physicians’ questioning turns at talk were not included in the analysis. See Table 2 for details.
Table 4: Single-Unit Questioning Turns and Answers/Responses

<table>
<thead>
<tr>
<th>Excerpt #/Sequence #</th>
<th>Question Type</th>
<th>Question</th>
<th>Answer/Response Type</th>
<th>Answer/Response</th>
<th>Exemplar #</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/18</td>
<td>YNI</td>
<td>Any chang[es]?</td>
<td>Preferred answer /No delay</td>
<td>[No].</td>
<td>1</td>
</tr>
<tr>
<td>21/4</td>
<td>YND</td>
<td>So it had gone up (0.3) a:t (0.2) the start of the session.=</td>
<td>i) Elaboration/ account</td>
<td>[No.] I had enough.</td>
<td>2</td>
</tr>
<tr>
<td>3/7</td>
<td>YNI</td>
<td>Has there been any n ew pain that’s come up (0.3) apart from the- your regular [pain].</td>
<td>ii) Deferred</td>
<td>(. ) M-more or less yeah it’s okay yeah.</td>
<td>2</td>
</tr>
<tr>
<td>33/20</td>
<td>YND</td>
<td>So it sounds like it’s (0.2) it the pain is:: (0.5) is well controlled.</td>
<td>b) Not type-conforming</td>
<td>(. ) Occasionally.</td>
<td>2</td>
</tr>
<tr>
<td>14/19</td>
<td>YNI</td>
<td>U::m:: (0.2) do you feel it occasionally you said.</td>
<td>i) Deferred</td>
<td>[more or less] the same.</td>
<td>2</td>
</tr>
<tr>
<td>35/22</td>
<td>YND</td>
<td>Weakness an[d pain]</td>
<td>Preferred answer with delay</td>
<td>(0.7) No.</td>
<td>3</td>
</tr>
<tr>
<td>8/17</td>
<td>YNI</td>
<td>Is there any pain in your back?, (. ) right now?</td>
<td>a) Type-conforming</td>
<td>(0.5) No</td>
<td>3</td>
</tr>
<tr>
<td>9/17</td>
<td>YNI</td>
<td>In here?</td>
<td></td>
<td>(0.5) No</td>
<td>3</td>
</tr>
<tr>
<td>22b/7</td>
<td>YND</td>
<td>No chest pain or palpitations.</td>
<td></td>
<td>(0.5) No</td>
<td>3</td>
</tr>
<tr>
<td>27/10</td>
<td>YND</td>
<td>So you’re able ta (0.2) ta do activities that may be you weren’t able ta do before.</td>
<td></td>
<td>(1.0) Yeah-yeah-ah:-um yeah.</td>
<td>3</td>
</tr>
<tr>
<td>Excerpt #/ Sequence #</td>
<td>Question Type</td>
<td>Question</td>
<td>Answer/Response Type</td>
<td>Answer/Response</td>
<td>Exemplar #</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Yes/No Interrogatives (YNIs) and Yes/No Declaratives (YNDs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18/23</td>
<td>YNI</td>
<td>Any pains?</td>
<td>Preferred answer with delay a) Type-conforming i) qualified</td>
<td>(1.2) No (0.4) not right now.</td>
<td>4</td>
</tr>
<tr>
<td>32/19</td>
<td>YND</td>
<td>It’s alwa- you always feel it there.</td>
<td></td>
<td>(0.2) Y:eah:: sometimes yeah but ah::</td>
<td></td>
</tr>
<tr>
<td>17/21</td>
<td>YNI</td>
<td>An::d do you ever wake from (0.5) u:m: (. ) wake in the middle of the night because of pain?</td>
<td>ii) deferred</td>
<td>(1.0) Mm::: no.</td>
<td></td>
</tr>
<tr>
<td>19/24</td>
<td>YNI</td>
<td>Any any new pains in the back here?</td>
<td></td>
<td>(0.2) New? (0.2) N:::o: no new.</td>
<td></td>
</tr>
<tr>
<td>24/9</td>
<td>YND</td>
<td>It’s just there.</td>
<td></td>
<td>(0.4) I-ju-it’s there yeah</td>
<td></td>
</tr>
<tr>
<td>29/11</td>
<td>YND</td>
<td>But not just normal touch.</td>
<td></td>
<td>(0.3) Not normal yeah. (0.7) no</td>
<td></td>
</tr>
<tr>
<td>2/6</td>
<td>YNI</td>
<td>So when you take the medication (0.3) do you have relief?</td>
<td>iii) deferred +</td>
<td>(1.2) Hm: (0.4) Yeah. (0.5) It’s:: (0.9) Yeah (0.4) I have relief</td>
<td>5</td>
</tr>
<tr>
<td>6/13</td>
<td>YNI</td>
<td>Or could it be better?</td>
<td></td>
<td>(1.0) I think very yeah it’s okay.</td>
<td></td>
</tr>
<tr>
<td>15/19</td>
<td>YNI</td>
<td>Does anything make it better?</td>
<td></td>
<td>(1.1) U::m (1.9) no I don’t need ah:: I think anything for this.</td>
<td></td>
</tr>
<tr>
<td>20/1</td>
<td>YND</td>
<td>In terms of the pain?, there’s no change.</td>
<td>b) Not type-conforming</td>
<td>(.) U::m (.) I don’t zink so no no it is not worse.</td>
<td></td>
</tr>
<tr>
<td>34/22</td>
<td>YND</td>
<td>Your pain is the same.</td>
<td></td>
<td>(0.2) The same</td>
<td></td>
</tr>
<tr>
<td>28/11</td>
<td>YND</td>
<td>Does it- it’s not painful.</td>
<td>i) + contrast</td>
<td>(0.7) Not painful: ah:: but it is different in some (respect). MAY BE A BIT More painful if you:: something like do something like this?, ah</td>
<td>6</td>
</tr>
<tr>
<td>Excerpt #/Sequence #</td>
<td>Question Type</td>
<td>Question</td>
<td>Answer/Response Type</td>
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<td>Exemplar #</td>
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<tr>
<td>30/15</td>
<td>YND</td>
<td>Okay it’s both legs:?:</td>
<td>Preferred answer with delay a) Not type-conforming ii) deferred</td>
<td>(0.5) B-both legs but more (. more the right one. (1.0) Right now it’s less.</td>
<td></td>
</tr>
<tr>
<td>26/10</td>
<td>YND</td>
<td>Your everyday life is less affected by the pain?</td>
<td>Dispreferred answer a) Type-conforming i) deferred + b) Not type-conforming i) deferred +</td>
<td>(0.9) Ah:: (0.3) y:eah:: I have some pain ah:: yeah: usually in my pelvis. (0.7) Ah:: (1.3) maybe it is not a new pain no. Because I have also tumour here. (0.9) This- (0.2) now it is different. (1.1) Ah:: (0.4) I am avoid-avoiding maybe (0.3) sitting for long (h) ti(h)me</td>
<td></td>
</tr>
<tr>
<td>12/19</td>
<td>YNI</td>
<td>U::m: (0.4) pt (0.2) an::d (2.3) are you-do you have any pain?</td>
<td>Dispreferred answer a) Type-conforming i) deferred +</td>
<td>(0.9) Ah:: (0.3) y:eah:: I have some pain ah:: yeah: usually in my pelvis.</td>
<td></td>
</tr>
<tr>
<td>13/19</td>
<td>YNI</td>
<td>Is that a new pain?</td>
<td>i) deferred +</td>
<td>(0.7) Ah:: (1.3) maybe it is not a new pain no. Because I have also tumour here.</td>
<td></td>
</tr>
<tr>
<td>23/9</td>
<td>YND</td>
<td>And your pain is:: (1.0) m:: (0.2) about the same it sounds like.</td>
<td>b) Not type-conforming i) deferred +</td>
<td>(0.9) This- (0.2) now it is different. (1.1) Ah:: (0.4) I am avoid-avoiding maybe (0.3) sitting for long (h) ti(h)me</td>
<td></td>
</tr>
<tr>
<td>7/16</td>
<td>YNI</td>
<td>Is any activity that you are avoiding to do because of the pain?</td>
<td>i) deferred +</td>
<td>(1.0) I don’t want to take more, (1.3) U::h:: (0.7)</td>
<td></td>
</tr>
<tr>
<td>1/3</td>
<td>YNI</td>
<td>Do you have any specific issues that you wanted to bring up?, with regards to your pain?, (0.5) this week.</td>
<td>Transformative answer</td>
<td>(1.5) M::uah:: it hasn’t changed a lot (. m:: (.) m:: (0.2) in the last hm</td>
<td></td>
</tr>
<tr>
<td>16/20</td>
<td>YNI</td>
<td>Could it be better controlled?</td>
<td>Response - Not answer</td>
<td>(1.0) I don’t want to take more,</td>
<td></td>
</tr>
<tr>
<td>5/13</td>
<td>YNI</td>
<td>Are you happy with where your pain control is now.</td>
<td></td>
<td>(1.3) U::h:: (0.7)</td>
<td></td>
</tr>
<tr>
<td>25/10</td>
<td>YND</td>
<td>So you feel like you’re-(0.2) better:: able tat a manage the pain now?</td>
<td></td>
<td>(1.0) U::m:</td>
<td></td>
</tr>
<tr>
<td>Excerpt#/Sequence #</td>
<td>Question Type</td>
<td>Question</td>
<td>Answer/Response Type</td>
<td>Answer/Response</td>
<td>Exemplar #</td>
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<tr>
<td>42b/12</td>
<td>WH-Q</td>
<td>What does worked (0.2) mean for you. (0.6) That the [radiation]</td>
<td>Answer/No delay</td>
<td>[Ah:: it’s]:::stopped (0.6) stopped pressing my nerves.</td>
<td></td>
</tr>
<tr>
<td>43/15</td>
<td>WH-Q</td>
<td>Where. What [part of] yer body.</td>
<td></td>
<td>[Where?] =Ah (0.3) it’s usually in my pelvis and ah:: yeah it’s usually in my pelvis. (0.8) So I have some like unusual feelin from the outer side of my legs and my feet.</td>
<td></td>
</tr>
<tr>
<td>40/4</td>
<td>WH-Q</td>
<td>How is your::: (.) pain after this last chemo session?</td>
<td>Answer with delay</td>
<td>(1.2) It hasn’t changed ah:: (0.7) I dunno. (0.2) With this new chemo I: I usually ah (.) I:::-I have more pain:, especially in my pelvis.</td>
<td></td>
</tr>
<tr>
<td>38/3</td>
<td>WH-Q</td>
<td>U:::m::: so couple things I wanna know is how is your pain.</td>
<td></td>
<td>(1.3) U:::m (2.0) I still have pain. (0.5) Yeah. (1.5) U:::m (0.3) but I having better that it’s stopped growing in my::: ah::: ah: my pelvis (0.2) Cuz I had radiation.</td>
<td>11</td>
</tr>
<tr>
<td>41/9</td>
<td>WH-Q</td>
<td>And so Instead of the having the pain: pressing on your nerves what’s the pain feel like now?,</td>
<td></td>
<td>(2.4) Now:ah ho-how i-it’s like PREsent ah-i-i it’s present.</td>
<td>12</td>
</tr>
<tr>
<td>36/19</td>
<td>WH-Q</td>
<td>When when when do you notice it.</td>
<td></td>
<td>(0.9) When:? I always notice it.</td>
<td>13</td>
</tr>
<tr>
<td>37/6</td>
<td>WH-Q</td>
<td>And how is that helping your pain?</td>
<td>Response - Not Answer with delay</td>
<td>(0.7) Ah it’s ah yeah (0.2) it’s::: more or less okay yeah.</td>
<td>14</td>
</tr>
<tr>
<td>39/9</td>
<td>WH-Q</td>
<td>Tell me how your pain’s different.</td>
<td></td>
<td>(1.1) I:::-it’s Pain is always ah something like present but it is something like different. I don’t know how. But i- ah i- it was different before?</td>
<td></td>
</tr>
<tr>
<td>Excerpt #/Sequence #</td>
<td>Question Type</td>
<td>Question</td>
<td>Answer/Response Type</td>
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<tr>
<td>42a/15</td>
<td>WH-Q</td>
<td>What is the pain?</td>
<td>Response - Not Answer with delay</td>
<td>(1.2) What?</td>
<td></td>
</tr>
<tr>
<td>48/24</td>
<td>ALT-Q</td>
<td>Where does it hurt the most in your back. (0.5) Or [in your pelvis].</td>
<td>Not repair a) Type-conforming</td>
<td>[In my back it’s usually not. It’s like ah pelvis ah::: (0.2) more here from the right side.</td>
<td></td>
</tr>
<tr>
<td>47/15</td>
<td>ALT-Q</td>
<td>And when you say unusual is: it: is: more painful or is (0.3) feel different?</td>
<td>Repair a) Type-conforming/No delay i) account</td>
<td>[As in] feel different ah::: (0.2) not normal feelin, because here for example is everysing normal as it was before the cancer.</td>
<td>15</td>
</tr>
<tr>
<td>45/6</td>
<td>ALT-Q</td>
<td>I mean- (0.4) does it get from like (1.2) does it ever get down to zero or do you always have (0.3) pain?</td>
<td>b) Not type-conforming with delay</td>
<td>(0.7) Ah::: (0.2) I have pain more when when I am sittin.</td>
<td>16</td>
</tr>
</tbody>
</table>

**WH-Questions (WH-Qs)**

**Alternative Questions (ALT-Qs)**

**Questioning Turns Not Included in the Analysis**

### Unclassifiable Turns

1. On two occasions P performs an anticipatory completion (see Lerner, 1996) of the physician’s turn. As a result, the physician’s question was incomplete and it was not possible to determine what type of question was going to be asked.

2. The physician is conducting a physical examination of P off camera; so it is not possible to determine what she means by “this area.” Possibly, “this area” refers to: a) “pelvis” uttered previously; b) the second question “In the hip area?;” or c) another area on P’s body that the physician is gesturing to. It is also possible that this is another example of an ALT-Q with no “or” connecting the two options (i.e., “in this area (pelvis or some other area)” or “In the hip area?”).
### Questioning Turns Not Included in the Analysis

<table>
<thead>
<tr>
<th>Reason</th>
<th>Question</th>
<th>Answer/Response</th>
<th>Sequence #</th>
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<tbody>
<tr>
<td>3. On another occasion when the physician is conducting a physical examination P and R are off camera; so it is not possible to determine what R means by “here?” and whether or not P provides an inaudible response (e.g., head shake, mouthing a response).</td>
<td>Here?</td>
<td>(0.2)</td>
<td>17</td>
</tr>
<tr>
<td><strong>Repetition</strong></td>
<td>One physician asks the same question twice. P indicates that he did not hear the question the first time because his talk was overlapping some of the question. Given that the questions are lexically identical, and the physician’s repeat is an other-initiated self-repair (for hearing clarification), these two questions were counted as one.</td>
<td>Is that [a new] pain?</td>
<td>[usually] Ah?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is that a new pain?</td>
<td></td>
</tr>
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</table>
All 44 of the question-answer adjacency pairs (Q/A-APs) were analyzed using the four dimensions of question design identified in Chapter 1: agenda setting, presuppositions, preferences and epistemic stance. These analyses provide an understanding of: (a) the types of questions that the physicians used during the assessment of a patient’s experiences of pain, and (b) the ways in which the patient responded to these questions. Exemplars discussed in this chapter were selected from the 44 Q/A-APs to demonstrate either prototypical or exceptional instances of talk from each grouping. Particular attention is given to deviations from the basic Q/A-APs and special features in the talk. The last column in Table 2 identifies the exemplars that are used to demonstrate the findings in this chapter.

Yes/No Interrogative and Yes/No Declarative Questions

Although YNIs and YNDs are often lumped together in the literature as polar questions, there is a distinct difference between them. A speaker initiating an action using interrogative form communicates to the respondent that he/she is uncertain about some piece of information, which “heighten(s) the accountability by treating the matter as in question” and, thus, making relevant an “answer” from the respondent. Further, when responding to YNIs speakers often “produce...
some elaboration of the action” (Raymond, 2010, p. 95). In contrast, a speaker uses a declarative question as a way of making an assertion or claim about a matter when he/she assumes to know about the matter, but would like to have the assumption validated (Heritage, 2010; Raymond, 2010). The use of a declarative question makes relevant a confirmation from the respondent and YNDs “effectively constrain sequence expansion” (Raymond, 2010, p. 95) or elaboration. However, the difference between YNIs and YNDs does not preclude grouping them together for analytic purposes because they have two important common features: as polar questions they have the same action agenda (i.e., the particular restricted action that the speaker requests the respondent perform) and they possess relatively similar inherent epistemic stance qualities (i.e., the questioner is less knowledgeable [K-] than the respondent [who is K+]). By design, polar questions set the kind of action agenda required of a respondent within the narrow limits of a yes (or equivalent token) answer or a no (or equivalent token) answer (Heritage, 2010; Heritage & Clayman, 2010; Raymond, 2003, 2010). Since the action agenda of the physicians’ questions is the same for all the YNI and YND exemplars in this section, the analysis with respect to the action agenda reported in this section is confined to P’s answers (or responses) to questions and whether or not his answers (or responses) conform to the action agenda of the questions. Further, since the analysis of epistemic stance of the physicians’ questions and P’s next turn answers (or responses) is similar to the analysis outlined in Chapter 1, the exemplar analyses in this section will not address epistemic stance except where there are variations from the basic pattern.

40 By virtue of asking a question that seeks information, a speaker positions himself/herself in a relatively unknowing (K-) epistemic stance in relation to a projected knowing stance (K+) of the respondent for the topic being discussed.
**Exemplar 1: YND; preferred answer with no delay**\(^{41}\). Prior to Exemplar 1, P tells R2 that he had experienced pain when he first started his most recent chemotherapy treatments, but that the pain diminished over the course of the treatments. In reply to this report of pain, R2 produces the gist formulation\(^{42}\) in Lines 1 to 7 that summarizes P’s description of his pain as “constant” while he was having chemotherapy\(^{43}\). In Lines 8 to 16, P produces an answer that corrects R2’s interpretation of his report of pain, stating that the intensity of his pain “increased” when he began the chemotherapy treatments.

(1) [C6P2: 99-200]

1. R2: >And so< your perception is that
2. the pain has been CONstant. It hasn't
3. deCReased or it hasn't increased
4. in with this last session?=
5. P: =>Yeah yeah it< Increased when: they began
6. [the new]chemo?,
7. R2: [ Right ]
8. P: and there it is:::
9. (1.1)
10. or else
11. (.)
12. the same lef,
13. (0.6)
14. R2: → So it had gone ↑ up
15. a:t
16. (0.2)
17. the start of the sessions.=
19. (1.1)
20. R2: ↑Ok;ay.
21. (0.6)
22. P: I'm usually I have pain when I am SITtin.
23. (0.4)

\(^{41}\) In each exemplar the Q/A-AP is bolded and there is a side arrow that signals the first pair part (FPP; i.e., the question) and the second pair part (SPP; i.e., the answer or response). The talk before and after the Q/A-AP: (a) shows the sequence of talk in which the Q/A-AP is located; and (b) provides some immediate context for each Q/A-AP.

\(^{42}\) A gist formulation is a current speaker’s summary of another speaker’s previous discourse (Heritage & Watson, 1979).

\(^{43}\) For analysis of the gist formulation in Lines 1 to 7 in Exemplar 1, which is a YND in a multi-unit turn, and P’s answer in Lines 8 to 16 please see Exemplar 21.
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

29 R2: Yep.
30 (0.6)
31 •hh [You're sitting's]
32 P: [ But not ↑not ]
33 (0.3)
34 ↑not
35 (0.2)
36 when I am standing, when I am standing where's no pressure
37 so as
38 (0.6)
39 mo-
40 (0.2)
41 almost no pain.
42 (1.3)
43 R2: Okay.

Question. In Line 18, R2’s reformulated gist formulation begins with a “So” discourse marker. The so-preface in this instance conveys that R2 is resuming a temporarily interrupted line of telling (see Bolden, 2006). This “So” bridges this reformulation to R2’s previous talk. The rising intonation at the beginning of the word “↑up,” followed by the 0.3-second pause, conveys that R2 is seeking confirmation regarding this interpretation of what P said about his experiences of pain. Further, the 0.3-second pause creates a possible transition relevance place (TRP) at which P could confirm R2’s reformulated gist formulation. Given that R2 misinterpreted this information previously (Lines 1 to 7, as displayed by P’s answer in Lines 8-9, 12-16), the pause in her turn provides P with an opportunity to correct her interpretation thus far. When P does not produce a confirmation after “up” (i.e., during the 0.3-second pause), R2 continues by producing an elongated “a:t” that displays R2’s continued occupancy of the turn space. This action helps with the progressivity of the talk by making P’s non-response after “up” less noticeable because it takes the form of a beginning turn increment which displays that R2 is still occupying the turn space. R2 produces another increment to her turn with “the start of the sessions.” Stressing “start” differentiates the time frames of P’s experiences of pain (i.e., start of the chemotherapy session versus later
in the chemotherapy treatments).

R2’s question in Exemplar 1 explicitly enquires about the severity and treatment aspects of pain. The topical content that P is to be addressing with his confirmation is his pain in relation to the chemotherapy treatments. The presupposition in R2’s YND is that P had pain prior to his chemotherapy session. The grammatical design of R2’s YND prefers a yes-type answer and discourages elaboration. As well, the design of R2’s YND displays the principle of recipient design (see Boyd & Heritage, 2006): R2’s reformulated gist formulation YND is based on P’s correction of her earlier gist formulation. Further, R2’s YND displays the principle of problem attentiveness (see Stivers, 2007): the question is designed to seek additional information about the presupposed problem that P had pain in relation to his latest chemotherapy sessions.

Answer. P’s immediate preferred type-conforming answer “=Y:eah,” after R2’s completion of “the start of the sessions.=,” demonstrates P’s (a) alignment with the answer preference of R2’s gist formulation in Lines 18 to 22; (b) willingness to provide an answer that conforms to both the type of action required by R2’s YND and the topic of her question, including the aspects of pain enquired about; and (c) confirmation of the inherent presuppositions in the question. Given that R2’s first gist formulation was incorrect, it is plausible that the reason P does not answer after the TRP at “↑up” is that he is waiting to ensure that R2’s reformulated gist formulation is correct before he provides a confirmation.

Exemplar 2: YND; preferred answer with no delay. The bolded Q/A-AP in Exemplar 2 is another example of P providing a preferred answer with no delay, but this exemplar also illustrates several other interesting features. Specifically, R5 demonstrates
an “emergence from incipiency” (see Bolden, 2009, p. 977) with a so-prefaced YND and she performs a self-initiated, self-repair (see Schegloff, 2007) in her question. Also, P provides a deferred, type-conforming answer that contains a partial repeat of R5’s question and a word replacement that serves to adjust the terms of the question.

Prior to Exemplar 2, R5 displays attempts to assess P’s experiences of pain by asking questions such as: (a) “Are you-do you have any pain?” (no pain)\(^{44}\); (b) “Is that a new pain?” (new); and (c) “When when when do you notice it ((the pain))?” (time or occasion)\(^{45}\). P’s answers to these questions identify some aspects of his experiences of pain: (a) “I have some pain usually in my pelvis” (site); (b) “maybe it is not a new pain no. Because I have also tumour here” (new); and (c) “I always notice it” (frequency).

R5’s assessment of P’s physical pain continues with attempts to determine if there are some specific activities that P does to help alleviate his pain: “Does anything make it better?” (management/control). P replies that he does not “need anything” for his pain, which is in line with the management/control aspect in the question. Then P explains at length to R5 the amount of pain medication he has been taking and the frequency with which he has been taking it (part of which is on Lines 1 to 3). During this part of the interaction, R5 primarily enacts alignment with P’s talk via continuers (e.g., “Uh huh” and “Uh hm”) and receipt tokens (e.g., “Yeah” and “Okay”; Lines 5 and 9).

(2) [C17P2: 497-544]
1 P: It was everyday so
2 R5: Yeah
3 P: that's ten pills weekly.
4 (.)
5 R5: Yeah.
6 (0.2)
7 P: For example.

\(^{44}\) For a complete analysis of this question and its corresponding answer, please see Exemplar 7.

\(^{45}\) For a complete analysis of this question and its corresponding answer, please see Exemplar 13.
Question. R5’s “So”-prefaced YND resumes the previously suspended topic (see Bolden, 2009) of P’s experiences of pain versus the medication he is taking. After the “So”-preface, the remainder of R5’s YND is framed with an “evidential” (see Chafe & Nichols, 1986 as cited in Heritage & Clayman, 2010, p. 160; see also Peräkylä, 1998) “it sounds like.” In medical contexts, physicians use evidentials to reference what “the physician is seeing, feeling, hearing, or sensing” (Heritage & Clayman, 2010, p. 160). Peräkylä (1998) argues that physicians use evidentials when there is a temporal separation between the topic that was previously discussed and the action required in the current turn (e.g., yes/no-type answer). R5’s evidential “it sounds like” verbally retrieves
the earlier topic context, while simultaneously marking the upshot formulation\textsuperscript{46} YND as tentative and in need of confirmation (see Peräkylä, 1998) but not elaboration.

The evidential in R5’s turn is followed by a self-initiated, self-repair (see Schegloff, 2007) “it’s: (0.2) it the pain.” In this phrase, R5 demonstrates that she recognizes that the word “it” (in “it’s”) may be viewed as a trouble source. That is, based on the immediately preceding talk, P may not know that R5’s “it” references the earlier topic of P’s experience of pain; thus, R5’s repetition of “it” explicitly identifies the perceived trouble source (i.e., she self-initiates a repair). This trouble source is then linked with the topic of P’s experience of pain with the self-repair “the pain.” In sum, R5’s self-initiated, self-repair explicitly grounds this YND question in the earlier, suspended talk about P’s pain.

R5’s bolded YND in Exemplar 2 summarizes the management/control aspect of P’s physical pain (i.e., his pain is well controlled). This summary is in relation to the earlier exchange in which R5 enquired “Does anything make it better?”, to which P replied “I don’t need I think anything for this.” R5’s question presupposes that: (a) P has pain, and (b) efforts have been made to control his pain. This YND is designed to prefer a yes-type confirmatory answer. As well, the present tense “is well controlled” in R5’s question implies that P’s pain has been constant across time. Thus, R5’s YND displays the principle of optimization (see Heritage, 2002; Heritage & Clayman, 2010; Stivers & Heritage, 2001): the question is designed so that the preferred answer confirms the positive outcome that P’s pain is well controlled currently and across time. The optimized design of R5’s YND discourages elaboration.

\textsuperscript{46} An upshot formulation is one speaker’s formulation of what another speaker said via drawing out the relevant implications of the other speaker’s talk (Antaki, Barnes & Leudar, 2005).
**Answer.** P provides a type-conforming answer to R5’s YND that is in line with the management/control aspect of his pain. However, P’s “yeah” (Line 19) answer is deferred by the non-committal hedge “M-[more or less].” By deferring his type-conforming answer, P registers a qualification to his answer before replying to R5’s question (see Heritage & Raymond, 2010). That is, P conveys to R5 that his answer does not accept the terms of her YND unconditionally. More specifically, the non-committal nature of “more or less” as a hedge allows for a possible hearing that P’s control of pain may be better or worse than implied by “well” and/or is not consistent across time; therefore, P’s answer does not accept the optimized proposition that his pain “is well controlled”. The qualification in his answer comes into play when he repeats R5’s use of the pro-term “it’s” (his pain) before replacing her description of his pain as “well controlled” with his descriptor of “okay.” According to Stivers and Hayashi (2010), “replacement transformations” (Stivers & Hayashi, 2010, p. 11) of some component of a turn demonstrate a resistance to a question’s design. “Is well controlled” implies that P’s current pain management plan is appropriate and does not need to be modified. P’s answer adjusts this proposition by replacing “well controlled” with “okay.” “Okay” implies that there is room for improvement in the pain management strategy for P. One interpretation of P’s answer is that it downgrades the description of his experience of pain from “well controlled” to “okay.” Also, his answer highlights a contrast between R5’s and his perceptions of the current state of his pain control. The repeat of “[yeah]” after “okay” adds to the contrast being built between what “well controlled” conveys and what its replacement “okay” conveys by affirming the appropriateness of “okay” as a descriptor for his experience of pain.
Another interpretation of P’s answer, specifically his repeat of “yeah” after his replacement of R5’s “well controlled” with “okay,” is that the second “yeah” is a recycling of his turn-initial, type-conforming “yeah” answer at the beginning of Line 19. The recycling re-iterates the type-conformity of his answer as a means of recasting the pain management as adequate and not in need of further intervention, despite his report that the pain management is less optimal than “well controlled.” This interpretation is suggested by: (a) his non-committal “more or less” (Line 17) that seems to be designed to manage the interactional dilemma that is created by his report of pain, which would make relevant an offer for a change to the pain control from the physician; and (b) the subsequent dialogue between P and R5 in Line 22 in which R5 pursues the possibility that the pain management strategy for P may need to be adjusted (i.e., he may need more pain medication and/or different medication) by asking “Could it ((the pain)) be better controlled?” P’s answer of “I don’t want to take more medication. I have a lot of chemicals inside” (Lines 24 and 30) disaffiliates with R5’s stance, as displayed in her question, and transforms the topic agenda of her question from P’s satisfaction with the pain control to an explicit rejection of taking more medication. P’s answer also provides an account for why he rejects more medication (i.e., he currently has a lot of chemicals in his body).

The second interpretation suggests the possibility that, in this instance, P’s troubles-resistant talk (see Jefferson, 1988) (i.e., “more or less” in Line 17, “okay” in Line 19, and “I don’t want to take more” in Line 24) discursively minimizes the telling of his pain. Also, his rejection of taking more medication (Lines 24 and 30) pre-empts R5’s

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47 See Exemplar 10 for a full analysis of this question/answer adjacency pair.
offer of more medication with “There’s no need to be in pain (0.5) we can always try” (Lines 36 to 38) to which P re-iterates his rejection for more medication with “not need to.”

**Exemplar 3: YNI; preferred answer with a delay.** The bolded Q/A-AP in Exemplar 3 highlights P’s production of a preferred, type-conforming answer that is delayed. This exemplar takes place out of range of the camera because P is on the examining table. Consequently, it is not possible to know exactly what non-verbal activities are occurring.

Just prior to Exemplar 3, R4 is listening to P’s lungs with a stethoscope while P performs several deep breaths. R4 instructs P to stop deep breathing. In Lines 1 to 3, R4 indicates to P that she wants to listen to his lungs via his back. In Line 18, R4 thanks P for his participation in this part of the physical examination.

(3) [C10P2: 890-947]

1 R4: I wanna listen to the back?
2 (1.5)
3 So the same. Breath in and out?
4 (0.5)
5 P: Hhhhh
6 (2.3)
7 Hhhhh
8 (2.1)
9 Hhhhh
10 (2.0)
11 Hhhh
12 (2.2)
13 Hhhhh
14 (2.1)
15 [Hhhhh]
16 R4: [Okay].
17 (.)
18 Thank you very much.
19 (1.0)
20 \text{Is there any pain in your back?},
21 (.)
22 right now?
23 (0.7)
24 P: \text{No}.= 
R4: =In here? (0.5)
P: °°No°°. (.)
R4: No. (.)
P: No no °°no°°. (1.0)
R4: Here?, (0.2)
No pain in the back.

Question. R4’s YNI in Line 20 is a no-pain question (i.e., it makes relevant an answer that P does not have pain to report in his back). The existence of pain is qualified with site and time. The topic agenda for R4’s YNI is P’s experience of pain in his back. Addition of the tag phrase “right now?” in Line 22 explicitly indexes the shift from a general time frame to the present. The negative polarity item “any” favours a no-type answer and discourages elaboration. R4’s YNI displays the principle of optimization: the preferred answer confirms an optimistic outcome that P is not experiencing pain in his back at this time. The optimization of R4’s question may be related to P’s earlier report in the consultation that he is not currently experiencing any pain, although P’s medical file states that P has metastasized lung cancer and he has experienced pain in his back previously. The optimization of the question also discourages elaboration. The sequence organization of the talk in Exemplar 3 is indicative of a history-taking routine checklist objective (see Stivers & Heritage, 2001). That is, in order to assess the current state of P’s experience of pain in his back area, R4 asks a series of routine questions that only require yes- or no-type answers. The series of questions R4 asks P in Exemplar 3 follows the pattern identified by Stivers & Heritage (2001). Specifically, R4 starts with a fully formed YNI (Lines 20 to 22), which is followed by a process of ellipsis of increasingly truncated questions (“In here?” – Line 25 and “Here?” – Line 33).
Answer. P produces a preferred, type-conforming “No” answer. P’s answer is in line with the aspect of pain enquired about in R4’s questions and it indicates that P accepts the action and topic agendas of R4’s question. Also, P’s preferred answer aligns to the preference structure of R2’s question. However, P’s answer is delayed by 0.7 seconds. Since this exemplar takes place out of camera range, it is not possible to determine if the delay is related to possible non-verbal activities (e.g., gestures, diverted gaze), or reflects that P may still be a bit winded from the previous deep breathing and may need the 0.7 seconds to recover before answering. Considering that P’s primary cancer is lung cancer, this explanation is plausible.

However, if there are no notable non-verbal activities occurring during this exemplar, and P is not experiencing troubles regaining his breath, the 0.7-second delay would indicate that P views something about R4’s question as problematic. For example, it is possible that P experienced pain in his back since his last visit but R2’s question leaves no room for such a reportable. That is, the negative polarity item “any,” the tag phrase “right now” that indexes his answer to the present time, and the optimized question discourage P from disclosing any information beyond his type-conforming, preferred answer. Although P is provided with three subsequent opportunities to report back pain (i.e., Line 25 – “In here?”; Line 33 – “Here?”; and Line 35 – “No pain in the back.”), these questions (Lines 20, 25 and 33) exhibit the routine checklist objective and also discourage any answer other than “No.” It is possible that P’s minimal answers of “No” (Lines 24, 27 and 31) demonstrate that P is orienting to the routine checklist objective and the imposed time frame of “right now.” As previously noted, the lack of video during this interaction makes it impossible to ascertain what the 0.7-second delay
prior to P’s answer means.

**Exemplar 4: YNI; preferred answer with a delay.** Exemplar 4 is a second example of P producing a preferred answer with a delay, but this time P adds a qualifier to his answer. As in Exemplar 3, this exemplar takes place during R5’s physical examination of P and out of range of the camera. Consequently, it is not possible to know exactly what non-verbal activities are occurring.

Prior to R5’s question in Line 18, she checks P’s strength in his legs (Lines 1 to 7) and she provides P with the positive assessment of “Good” (Line 11). R4 then asks P to lie down on the examining table (Line 12). R5 palpates P’s abdomen for 8.2 seconds, after which she asks him the question in Line 18.

(4) [C17P2: 954-987]

```
1  R5:  And now kick your leg-
2   (.)
3   push your leg out.
4   (1.9)
5   ↑0↓kay
6   (0.3)
7   and this side.
8   (1.9)
9   Okay.
10  (0.4)
11  Good. pt •hhh
12  And do you wanna lie down and I'll feel your belly?
13   (6.5)
14   °Good°
15   (1.4)
16   °     °
17   (0.3)
18  → Any pains?
19   (1.2)
20  P:  → No.
21   (0.4)
22  → °Not right now°.
23   (0.7)
24  R5:  Big breath in?=
25  P:  =•hhh ↑•hhh
26   (0.4)
27  R5:  °Good°.
28   (0.3)
29  P:  HHHhh
```
Question. In Line 18, R5 asks a no-pain question (i.e., the question makes relevant an answer that P does not have pain to report). Even though R5 is examining P’s abdomen when she asks “Any pains,” the design of her question sets a broad context for P’s experience of pain(s). That is, she asks a non-specific question that leaves open an opportunity for P to discuss the aspect(s) of pain most relevant to him if he chooses to reply with a dispreferred answer. The use of the plural form of pain demonstrates that R5 is orienting to the possibility that P is experiencing pain in more than one site, that his pain is intermittent, and/or that his pain embodies other aspects (e.g., severity, quality). The specific topical content that P is to be addressing in his answer is whether he has pain. The negative polarity item “Any” in R5’s question orients towards a preference for a no-type answer and discourages elaboration. R5’s question displays the principle of optimization: the preferred answer confirms a positive outcome that P is not experiencing pains during the physical examination.

Answer. P provides R5 with the preferred answer of “No,” but with features of a dispreferred design. That is, P’s answer occurs after a significant delay and in conjunction with the minimal post-expansion (see Schegloff, 2007) “Not right now,” which qualifies his answer with an explicit temporal element. This qualifier limits P’s answer of “no” pains to the present point in time (“right now”) and implicitly conveys to R5 that his pain is not stable. That is, although he is not experiencing pains at that moment, he may have had pain since his last visit and he may experience pain in the
future. P’s answer conforms to the type of action the question solicits, but adds an explicit time aspect and implicitly refers to possible change(s).

**Exemplar 5: YNI; preferred answer with a delay.** Exemplar 5 is an example of P providing a type-conforming preferred answer with a delay, which is deferred by P’s production of “Hm:.”

Prior to R2’s question in Exemplar 5, R2 asks P why he reported on his Edmonton Symptom Assessment Survey (ESAS)\(^48\) form that he is experiencing more fatigue since his last visit to the clinic. P attributes the increase in fatigue to taking the prescribed medication. R2 asks P how much medication he is taking (Line 1). P reports the amount of pain medication he is taking (Line 2). R2 acknowledges receipt of P’s information and asks how the medication is helping his pain (Line 3). P hesitates before producing a non-committal answer in Lines 5 to 8 (for full analysis of this Q/A-AP see Exemplar 14).

(5) [C6P2: 298-363]

```
R2: And how much of the medication are you currently taking?=
P: =Ah two pills of oxycotton ten milligrams.=
R2: =Okay. And how is that helping your pain?
P: ↑Ah it's ↓ah yeah (0.7)
   (0.2)  it's::: >more or less<
   (0.6)
R2: → So when you take the medication
   (0.3)
   do you have relief?
   (1.2)
P: → °Hm:°
   (0.4)
   Yeah.
   (0.5)
   It's:::
   (0.9)
   Yeah
```

\(^{48}\) Every patient who attends the Clinic fills in the ESAS prior to each consultation. The patient’s answers on the most recent ESAS form are compared to the previous completed forms as a way of evaluating the progression of the patient’s experiences of the symptoms. A copy of the ESAS is in Appendix C.
I have relief.

R2: "Okay".

•hh I mean-

does it get from like

does it ever get down to zero or do you always have "pain"?

P: Ah::

I have pain more when when I am sittin'.

R2: Yes.

Question. R2 treats P’s answer in Lines 5 to 8 as non-committal and in Lines 10 to 12 she pursues an answer to her WH-Q in Line 3 using a more specific approach. R2’s YNI in Lines 10 to 12 is prefaced with the discourse marker “So,” which in this case indicates an upshot of the previous talk (see Johnson, 2002). The aspect of pain explicitly enquired about in R2’s YNI is effects of treatment. The topic agenda set by R2’s question is P’s pain relief when he takes the medication. R2’s question presupposes that P: (a) has pain that requires him to take medication; and (b) is taking the prescribed medication (the topic of discussion prior to the YNI in Lines 10 to 12). The grammatical design of R2’s question prefers a yes-type answer and it encourages elaboration. R2’s question displays the principle of problem attentiveness because it is a reformulation of R2’s WH-Q in Line 3 that pursues a more specific answer about the effectiveness of the current pain control. R2’s questions in Line 3 and the reformulation in Lines 10 to 12 are both in response to P’s report of experiencing pain (prior to this exemplar) and how much pain medication he is taking.
Answer. P eventually produces the preferred, type-conforming answer “Yeah” (Line 16). His answer: (a) is in line with the aspect of pain enquired about in R2’s question; (b) conforms to the action and topic agendas of the question; (c) confirms the inherent presuppositions in R2’s question; and (d) aligns with the preference structure of R2’s question. However, several features of P’s answer indicate that he views something about R2’s question as problematic: (1) the delay in his answer (via the “Hm:” and 0.4-second pause before his preferred answer); (2) several other pauses (i.e., hesitations) in his answer (“°Hm:°(0.4) Yeah. (0.5) It's:: (0.9) Yeah (0.4) I have relief.”) that indicate P is doing considering (see Jaworski, 1993); (3) his incomplete TCU beginning with “It’s::;”; and (4) the inclusion of a partial modified repeat (see Stivers, 2005) of R2’s question in his answer (“I have relief”).

It seems that the problem source is the lack of sufficient specificity of the topic in R2’s question. That is, the question does not specify what is meant by “relief.” Does relief mean: (a) the elimination of pain or a decrease in pain; or (b) a positive change in P’s experience of pain in his whole body or in some specific part of his body? P’s hesitant, preferred, type-conforming answer, which includes a partial modified repeat, shows P conforming to the design of R2’s question by applying the same generality to his answer that is in R2’s question. That is, P states generally that he has relief but he does not elaborate. The lack of elaboration in P’s answer at this point in the conversation makes it impossible for R2 to determine: (1) what having relief means to P; (2) how much relief P experiences when he takes the medication (i.e., the severity of P’s pain pre- and post-medication); (3) in which painful areas of P’s body he has relief (i.e., site); and (4) for how long P has relief (i.e., time).
The possibility that it is the meaning of relief that is problematic is introduced by R2 in Lines 26 to 32 when she pursues an evaluation from P regarding the severity and frequency with which he experiences pain. R2’s ALT-Q in Lines 26 to 32 is more specific (see Exemplar 16) than her previous question in Lines 10 to 12 of Exemplar 5. In reply, P informs R2 that he experiences an increase in pain when he sits for a long period of time (Line 36). P’s answer is in line with the severity aspect in R2’s question (“pain more”) but he does not address the frequency aspect; rather, he adds an occasion (i.e., sitting). Given that R2’s question in Lines 10 to 12 of Exemplar 5 is quite general, it is understandable why P would view the topic of the question about relief as problematic, and why he would not report the specific severity and occasion aspects in Line 36 to R2.

**Exemplar 6: YNI/YND; preferred answer with a delay.** Exemplar 6 is an example of P producing a preferred answer with a non-type-conforming dispreferred design. As well, P provides R3 with a contrast that effectively transforms his preferred answer to a dispreferred answer. During this exemplar, P is sitting on the examining table and only his lower body is visible. Consequently, it is not possible to know exactly what non-verbal activities involving his upper body are occurring.

Prior to R3’s bolded question in Exemplar 6 (Line 15), P informs R3 of a change in his physical condition in the form of a new symptom: unusual sensations in his legs. R3 asks P to describe the unusual sensations. P attempts to describe the sensations in Line 1 by stating that the area is not numb, he “can feel everything,” it is just a “different” feeling. R3 displays alignment by acknowledging receipt of this information (Line 3) and her pause of 0.9 seconds encourages P to continue his turn. In Line 5, P informs R3 that he is unable to describe this new sensation. R3 then proceeds to offer P several candidate
descriptors: “do you feel it less or do you feel it more” (severity) and “does it feel tingly or prickly” (quality). P rejects R3’s candidate descriptions in Lines 12 to 14.

(6) [C8P2: 750-779]

1 P: I can feel everythin but ah::: different.
2 (0.3)
3 R3: Okay.
4 (0.9)
5 P: I(hu-hu) don(hh) know how [to explain ]
6 R3: [And but you can]'t characterize
7 it. Like do you feel it LESS: or do you feel it mor::e
8 or does it feel ting:ly:: or
9 (0.9)
10 prickly?
11 (1.1)
12 P: No:: it doesn't
13 (0.8)
14 um: it does not prick ah:: prick ah:::=
15 R3: =Does it- it's not painful.
16 (0.7)
17 P: =Not painful: ah:: >but it is< different in some (respect).
18 (.)
19 MAY BE A BIT More painful if you:: something like do
20 something like this?, ah=
22 (0.3)
23 P: Not normal yeah.
24 (0.7)
25 [No].
27 (0.2)
28 Let's have yer shoes off if you don't mind.

Question. In Line 15, R3 asks a no-pain question in which the question explicitly states that the new sensation P is reporting is “not painful.” R3’s question begins with a YNI format “Does it.” She abruptly stops and performs a self-initiated, self-repair (see Schegloff, 2007) that changes the original YNI format to a YND, “it’s not painful.” According to Raymond (2010), the replacement of a YNI with a YND “regularly reflects a speaker’s concern with the implication that ‘not knowing’ may have for the sequence in question” (p. 98). In Line 15, R3’s YNI could imply that she is not familiar or knowledgeable about P’s new symptom, which could have some bearing on P’s
perception of her professional expertise. Switching to a YND format (“it’s not painful”) requires only a confirmatory answer from P, and R3 appears knowledgeable or familiar with P’s new symptom (i.e., this sensation is not painful).

The topic agenda set by R3’s YND is P’s lack of pain associated with his new symptom. R3’s YND prefers a no-type answer because it is polarized in a negative direction (i.e., the new symptom is not painful) (Boyd & Heritage, 2006). The presuppositions are that P: (a) is experiencing a new sensation in his legs; (b) is able to describe the new sensation in his legs; and (c) knows what “painful” feels like. Further, R3’s question displays the principle of optimization, but as noted above, might be overly optimistic in this context. The design features of R3’s question (i.e., phrased as a YND, preference for a no-answer and optimization) discourage elaboration from P.

Answer. P’s answer conforms to the topic agenda of R3’s question but not to the action agenda (i.e., he does not include either a yes or no or some equivalent token in his answer). P’s non-type-conforming answer in Line 17 begins with a repeat of “Not painful” from R3’s question. According to Pomerantz (1984), beginning an answer with a repeat of an evaluation from the speaker’s question (i.e., same evaluation) can operate as a “weak agreement” that “prefaces a disagreement” (Pomerantz, 1984, p. 68). In this case, P moves his talk from weak agreement to neither agreement nor disagreement then to disagreement, finishing his turn with a dispreferred answer. Specifically, P’s repeat of “Not painful” performs the same action as answering yes, but is not type-conforming (i.e., does not include an explicit yes or no). This first TCU in P’s multi-unit turn appears to agree with R3’s YND (i.e., P’s answer is initially in line with R3’s presumption that there is no pain associated with his new sensation). This is followed in Line 17 by an
P’s disagreement with “Not painful” begins with “A BIT More painful” (severity), which implies a change in his experience of pain. That is, P’s assessment that his legs are now a bit more painful explicitly states that he has pain in his legs and indicates a change in his experience of pain, which is a direct contrast to his earlier statement that his legs are not painful. This transforms his earlier answer from a preferred answer to a dispreferred answer. P completes his turn by indicating a qualification (prefaced by “if”) to his assessment of some pain: “you:: something like do something like this?,” (i.e., P indicates an occasion by thumping on his thighs with his fists). Although P’s answer acknowledges that he has pain, he minimizes (a) the extent of the pain by restricting it to a particular occasion, and (b) the significance of the pain with “may be a bit more painful” (i.e., he downplays the severity of the pain with “may be” and “a bit”).

Another way to explain P’s answer is that his turn-initial repetition of “Not painful” claims his greater K+ epistemic stance and social entitlement over the relevant information about his experience of pain than the YND question affords him (see Heritage & Raymond, in press). According to Heritage and Raymond (in press), turn-
initial repeats that are followed by “turn components that revise the initial position of the respondent” (Heritage & Raymond, in press, p. 12) allow the respondent to “break away from the terms of the question...which is then leveraged into a disconfirmation of the question’s declarative claim” (Heritage & Raymond, in press, p. 12). In Exemplar 6, P resists the action agenda of R3’s YND with an epistemically agentive turn-initial repeat of “Not painful,” (Line 17) which is leveraged into a continuation in Lines 17 to 20. In the continuation he explains that he has some pain, but only when he performs an extreme action, thus downgrading the severity of the problem and pre-empting any offer from the physician for more medication. In Line 21 the physician seeks confirmation that the pain does not occur with normal touch and P performs another turn-initial repeat in Line 23 with “Not normal, yeah,” thus reiterating his greater K+ epistemic stance and social entitlement to his experience of pain while simultaneously minimizing the severity of his pain and again pre-empting an offer of more medication.

Further, by withholding the required answer of either yes or no (or an equivalent token), P also demonstrates that he does not accept one or more inherent presupposition(s) in R3’s question (see Raymond, 2003). P’s rejection of at least one of the inherent presuppositions in R3’s question is supported further by his use of a repeat-prefaced answer (“Not painful”). According to Bolden (2009), a respondent often repeats part of a speaker’s question for two reasons: (1) to indicate that there is something problematic about the inherent presuppositions in the speaker’s question; and (2) to locate the problematic part, or bring it to light, by repeating it. It is possible that P finds the second presupposition (i.e., he is able to describe the new sensation in his legs) somewhat problematic. This is evidenced in two ways: (a) by the talk in Lines 1 to 14 in which P
states “I don’t know how to explain” and rejects R3’s candidate descriptions of his new sensation; and (b) by the progression of P’s talk; that is, his answer (Lines 17 to 20) moves from a definite “not painful,” to a weaker agreement “it is different in some (respect),” and finishes with a contrast (“may be a bit more painful”) to his earlier definite answer. Further, given that P repeats the optimized outcome of R3’s question (“not painful”), it is also possible that P rejects the optimized design of the question as overly optimistic.

The interaction between R3 and P in Exemplar 6 demonstrates the complexity of pain and shows the difficulty that can be experienced in articulating the nature of a personal experience, or even in identifying whether a new sensation is painful. P displays this difficulty by: (a) initially stating that he does not know how to explain the new sensation; (b) rejecting R3’s candidate descriptions of the frequency and quality of his pain; (c) describing the new sensation in his legs as “different in some respects”; (d) hesitantly admitting that his new sensation may be a bit more painful; and (e) imposing a qualification on his admission of more pain by stating that the pain occurs only when he thumps on his thighs, but not with normal touch.

The interaction prior to and in Exemplar 6 also illustrates P doing “troubles telling” (see Jefferson, 1984, p. 191). That is, over the course of several turns he presents a narrative regarding his experience of this new sensation in his legs. Although P is doing troubles telling, he does so in a troubles-resistant fashion (see Jefferson, 1988). That is, as in Exemplar 2, he discursively minimizes the severity of his pain in Lines 17 to 19 by first stating that the new sensation is “Not painful,” then by hesitantly admitting pain, yet playing down the effects of the pain (“may be a bit more painful”). Further, P displays
stoicism and that he is able to cope with the pain with fortitude by thumping noticeably on his thighs with his fists, rather than verbally describing the occasion when he experiences pain. According to Heritage and Robinson (2006a), patients will display troubles resistance by expressing “an objective ‘just the facts’ approach to illness, the avoidance of reports of pain (except as itself a symptom), fear, or sadness, or of volunteering ‘worst fears’” (Heritage & Robinson, 2006a, p. 76). P’s displays of stoicism and troubles-resistance convey an unwillingness to acknowledge that his pain is becoming worse and that by implication his cancer may be progressing. Also, his minimization of the pain allows him to portray himself as not needing to take more medication, thereby avoiding having to refuse an offer of more medication from the physician.

**Exemplar 7: YNI; dispreferred answer.** Prior to R5’s YNI in Line 17, R5 informs P that the scores he reported on his current ESAS form (for all of his symptoms) are similar to those he reported at his last visit (Lines 1 to 4). P answers with “Yeah more or less yeah” in Line 6 (i.e., he includes a hedge that conveys his hesitance to commit to a full agreement with R5’s assessment of no change in his symptoms). R5 produces a third position assessment “So that’s good,” positively evaluating the lack of change in P’s ESAS scores.

Prior to the interaction in Exemplar 7, the camera was accidently shifted and only P is visible on the video. This makes it impossible to determine gaze or to know exactly what non-verbal activities R5 may be doing that are visible only to P.

(7) [C17P2: 313-401]

1 R5: So it looks like an-
2 (0.6)
3 so everything els:e um on the score is about the same as it
4 wha-was what it was last time.
P: Yeah more or less [yeah].
R5: [Yeah].
So that's good.

R5: → U:::m:
pt
an:::d
>are you−do you have any pain<?
P: → Ah:::
y:eah:: I have some pain ah:: yeah: usually in my pelvis.

R5: Yeah.
P: Yeah.=
R5: =Okay.=
P: "There’s ah"
Sometimes I have a bit a little bit of here sometimes
but not ah: It is not:
*you know* sometimes only.

Question. R5’s YNI in Exemplar 7 is lexically connected to the prior talk through an and-preface. After the connection of the question with the immediately preceding talk, R5 suspends talk for 2.3 seconds. This lengthy pause can indicate that R5 is evaluating what would be the best approach for asking the next question (see Heritage, 2010) about P’s experience of pain. On Line 17, R5’s question begins with “are you” and then she abruptly halts her talk. A projectable completion of this question would be “in pain” or “in any pain.” R5 performs a self-initiated, self-repair (see Schegloff, 2007) from “are you” to “do you” before finishing with “have any pain?” The lexical shift in R5’s re-design of her question implicitly alters the time frame for P’s answer. That is, “are you”
sets the time frame for P’s answer at the present time, whereas “do you” is ambiguous; it may or may not confirm the time set in Lines 3 and 4 as the period since his last visit.

The topic agenda of R5’s question is P’s experience of pain. The inherent presupposition in R5’s question is that P is willing to report his pain. The lexical shift in the grammatical design of R5’s question changes the preferences inherent in her question. That is, “are you in pain?” prefers a yes-type answer and it encourages elaboration. In contrast, “do you have any pain?” includes the negative polarity item “any,” which orients towards a preference for a no-type answer from P and discourages elaboration. As well, R5’s question shifts from displaying the principle of problem attentiveness to the principle of optimization. That is, asking “are you in pain?” takes into consideration P’s previous experience of pain and that there is a possibility that he is currently experiencing pain (i.e., presumes pain). In contrast, “do you have any pain?” is designed so that the preferred answer confirms a positive outcome (i.e., presumes no pain).

**Answer.** P’s elaborated answer: (a) conforms to the type of action R5’s question solicits and to the topic agenda; and (b) accepts the inherent presupposition. But P’s answer displays several features of a dispreferred answer (see Boyd & Heritage, 2006; Pomerantz, 1984; Sacks, 1987): (1) it is delayed for 0.9 seconds; (2) the answer is prefaced by the discourse marker “Ah:::,” which is followed by another pause; and (3) the answer includes an account (“I have some pain ah:: yeah: usually in my pelvis”) that explains why the preferred answer “no” is not being done.

P’s answer further resists the limits placed on the type of answer expected of him by R5’s question with: (a) a partial modified repeat (see Stivers, 2005) of R5’s question (R: “do you have any pain” P: “I have some pain”); and (b) the replacement of “any pain”
in R5’s question with “some pain” in his answer (i.e., a replacement transformation; see Stivers & Hayashi, 2010). Partial modified repeats and replacement transformations are practices by which question recipients can resist some component of a question’s design while still providing an answer. It is possible that P is resisting the stance of the physician as overly optimistic. P’s elaborated answer resists the presumption of no pain in R5’s question, explicitly reporting pain and a specific site of the pain. As in Exemplar 6, P uses a minimiser (i.e., “some”) which downplays the extent of his pain. Further, he qualifies his declaration of pain by restricting the pain to a specific location and indicating that it is not always present (“usually”). P’s minimiser and qualification (which qualifies not only time but location) shows P’s troubles-resistance and demonstrates his stoicism.

**Exemplar 8: YNI; dispreferred answer.** This exemplar is another instance of P producing a dispreferred answer, but this time his answer is not type-conforming.

Prior to Exemplar 8, R4 and P are discussing what precipitates P’s use of the breakthrough pain medication (i.e., sitting for long periods of time; moving around a lot) and how much of the medication he is taking. P explains that his use of the breakthrough medication is variable depending on the circumstances. In Lines 1 to 2 of Exemplar 8, R4 offers P candidate occasions for when he needs to take the medication via recycling the two occasions P stated earlier. In overlap with R4 (Line 3) P reiterates sitting as an occasion and in Line 4 he adds a time qualification of “for a long time.” R4 acknowledges receipt of this information (“Okay”; Line 5) and she offers a gist formulation in Line 7 (“Mainly when sitting”). P also adds an account for why sitting for
a long time is a problem (i.e., there is pressure on his pelvis), which results in him taking more breakthrough pain medication (Line 15).

(8) [C10P2: 261-369]

1  R4: And that's basically when say that you need to move in
2  order to some[thing (or when you sit)].
3  P: [ Or: to sit ]
4  for a long time [yeah].
5  R4: [Okay].
6  (0.4)
7  Mainly when sitting.
8  (1.6)
9  P: When there is a pressure on my um:
10  (0.3)
11  on my [pelvis]
12  R4: [°Hm°]
13  P: so that's
14  (1.2)
15  I have to take more.
16  (0.4)
17  R4: °Uh huh°.
18  (0.9)
19  R4: →Is any activity that you are avoiding to do
20  because of the pain?
21  (1.1)
22  P: →Ah::
23  (0.4)
24  I am avoid-avoidin::g maybe
25  (0.3)
26  sitting for a long(h) ti(h)[me].
27  R4: [Um] hm.
28  (0.5)
29  P: °°That's] about it°.
30  R4: °Okay°
31  (0.4)
32  P: Pressure on my pelvis >ah I'm< avoiding this.
33  (.)
34  R4: °Uh huh°.
35  (0.4)
36  P: I have to: sleep (all) usually on my::: stomach?,
37  (0.2)
38  °°so°°.
39  (0.3)
40  R4: ↑0;kay.
41  (7.3)

Question. The topic agenda set by R4’s question (Lines 19 to 20) is activity P is avoiding because of the pain (i.e., consequences of pain). R4’s question presupposes that:
(a) P has pain; and (b) the pain might lead to avoidance of activities. R4’s YNI prefers a
no-type answer because of the inclusion of the negative polarity item “any.” Also, the use of the extreme case formulation “avoiding”⁴⁹ may bolster the preference for a no-type answer. R4’s stressed intonation on the first two syllables of “avoiding” conveys to P that she is only asking about those activities that he keeps away from because of his experience of pain. She is not inquiring about activities that he still does, even though he may find those activities difficult or uncomfortable to do because of his experience of pain. The no-preference of the question discourages elaboration.

\textit{Answer.} As in Exemplar 7, P’s answer resists the limits placed on the type of answer expected of him by R4’s question with a partial modified repeat of R4’s question (R4: “any activity you are \underline{avoiding}” P: “I am avoid-avoiding”). Specifically, P’s non-type-conforming (i.e., he does not say either yes or no or an equivalent token), dispreferred answer accepts the topic agenda of R4’s question (i.e., the partial modified repeat of the question displays cooperation or alignment with the topic agenda), but his answer rejects the type of action required by the question design. Also, P’s answer does not align with the preference inherent in R4’s question and it displays the features of a dispreferred answer similar to those outlined in Exemplar 7 (e.g., delay, ah-prefix).

An interesting feature of P’s answer is that his explicit reference to sitting connects his answer in Lines 24 to 26 to the talk prior to R4’s YNI in Lines 19 to 20; however, R4’s YNI does not include any words that lexically connect her question to the prior talk (e.g., an and- or so-prefix); rather, her YNI in Lines 19 to 20 is formulated as a new topic. That is, R4’s YNI ignores P’s prior talk about his problem of pain when he sits for a long time (Lines 3 to 4; 9 to 11), a problem that results in his increased use of

⁴⁹ In this case, “avoiding” is an extreme case formulation because it is polarized in an extreme negative direction.
the medication (Line 15). Further, the preference for a no-type answer (or a report of not avoiding any activity because of the pain) negates P’s problem of pain when he sits for a long time and the implications of that pain. P’s lengthy pause of 1.1 seconds, followed by the discourse marker “Ah” and a 0.4-second pause, displays that P is having a problem answering R4’s question, and that he is having a problem dealing with R4 asking him a question that he has already answered (see Robinson, 2006). The delay also displays P’s hesitance to repeat his earlier talk because “speakers do not normally tell recipients news that speakers figure that recipients already know” (Terasaki, 1976, as cited in Robinson, 2006, p. 26).

Another interesting feature of P’s answer is that his turn begins with the partial modified repeat “I am avoid-avoiding” that lexically stresses “am” and parts of “avoid-avoiding” and he lexically stresses the first part of “sitting”. P’s lexical stresses highlight that his prior talk has already answered R4’s question in Lines 19 to 20. P’s inclusion of the hedge “maybe” between “avoiding” and “sitting” acts to modify the harshness of his critique of R4’s question. That is, without the “maybe” P’s answer could have been interpreted as sarcastic because he repeats part of her question and lexically stresses his previous answer.

**Exemplar 9: YNI; transformative answer.** Exemplar 9 is an example of P providing a dispreferred, “transformative answer” (see Stivers & Hayashi, 2010, p. 1). Prior to the interaction in Exemplar 9, the camera was accidently shifted and only P is visible on the video. This makes it impossible to determine gaze or to know exactly what non-verbal activities R5 may be doing that are visible only to P.
Just prior to Exemplar 9, R5 asks P how much pain medication he is taking. P informs R5 of the quantity of pain medication in Line 1. R5 acknowledges receipt of P’s information in Line 3, to which P replies “For example” (Line 5). P’s answer downgrades the precision of the quantity he stated in Line 1 by qualifying that the quantity of “ten pills weekly” is an estimate or an example of how many pills he takes, not a consistent number. R5 accepts P’s qualification and produces the upshot formulation in Lines 9 to 13 that makes a positive assessment of the management/control of P’s pain (see Exemplar 2 for a detailed analysis of the Q/A-AP in Lines 9 to 17).

(9) [C17P2: 488-544]

1  P: that's ten pills weekly.
2   (.)
3  R5: Yeah.
4   (0.2)
5  P: For example.
6   (0.3)
7  R5: Okay.
8   (0.2)
9   So it sounds like it's:
10   (0.2)
11  it the pain is:
12   (0.5)
13  is well controlled.
14   (.)
15  P: M-[more or less]=
16  R5: [Hm:: or less]
17  P: =yeah it's okay [yeah].
18  R5: [Okay].
19   (0.4)
20  R5: → Could it be better controlled?
21   (1.0)
22  P: → I don't want to take more,
23   (0.5)
24  R5: *pt* °kay.
25   (0.6)
26  P: **hm**
27   (0.3)
28  medication. I have en-a lot of chemicals inside so
29   (0.2)
30  R5: Uh hm::.
31   (0.8)
32  Okay.
33   (1.3)
34  R5: There's no need to be in pain so
35   (0.5)
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

Question. R5 pursues the management/control aspect of P’s pain with her YNI in Line 20. The topic agenda of R5’s question is the level of P’s satisfaction (or dissatisfaction) with the current state of his pain control (i.e., either the type or the amount of pain medication P is taking). The presuppositions in R5’s question are that P: (a) has pain; (b) is taking medication to control his pain; (c) has at least some control over his pain; (d) might be willing to take more medication; and (e) might be willing to change how his pain is being controlled. The design of R5’s question orients towards a preference for a yes-type answer. Specifically, R5’s modal verb “Could” suggests that P consider the possibility that his pain (referenced by the pro-term “it”) may be better controlled. Further, in suggesting the possibility that P’s pain might be better controlled (via a question designed to prefer a yes-type answer), R5’s YNI displays the principle of problem attentiveness and encourages elaboration.

Answer: P’s dispreferred, non-type-conforming answer rejects both the type of action required by R5’s question and the topic to be addressed. P does this by providing an agenda-transforming answer (see Stivers & Hayashi, 2010) to R5’s question. That is, P’s answer in Exemplar 9 transforms the topic agenda of R5’s question from P’s

50 My use of the modal verb “might” is consistent with R5’s use of the modal verb “Could” in her question; that is, they both present a possibility for consideration.
satisfaction with his pain management/control to the amount of pain medication he is
taking to manage/control his pain. P’s transformative answer works to implicitly accept
some of the embodied presuppositions in R5’s question and explicitly reject other
presuppositions. Specifically, P’s transformative answer (“I don't want to take more”) does not deny that he has pain and that he is taking medication to control his pain. This is probably because this information has been discussed prior to this interaction and is more fact than presupposition. Also, it can be assumed that P has at least some control over his pain. This is based on the observation that P does not overtly demonstrate that he is in pain during this interaction. Given that P does not state that he is unwilling to consider alternative treatments such as acupuncture to help control his pain, he has not explicitly rejected presupposition five. However, P’s answer “I don’t want to take more,” does explicitly reject presupposition four.

P’s transformative answer does not negate that there may be a problem with his current pain management strategy; rather, it resists the notion that the problem can be best solved using more medication (because he already has “a lot of chemicals inside” of his body – Line 28). Although P’s answer expresses a resistance to take more medication (i.e., he does not “want”), at this point he does not emphatically state that he will not take more medication. However, the talk subsequent to P’s answer in Line 22 demonstrates that even when R5 explains to him that “there’s no need to be in pain,” (Line 34), and that the physicians can “work” to find a solution (Line 42), P declines R5’s offer of assistance with his pain by stating “I can stand this” (Line 44). P’s explicit orientation to a refusal for more medication in Lines 22 and 44 shows how the physician’s questions

51 Alternative treatments are suggested by the physicians at various times during the consultations. The orientation of the patient’s talk at this point toward medication use may reflect that the immediately prior talk was about medication use.
about pain, when answered by the patient with an affirmative, can occasion a recommendation or offer of additional or new medications by the physician. P’s refusal of more medication also displays stoicism and that he is able to cope with the pain with fortitude. Nonetheless, P leaves open the possibility that he may need assistance at a future point in time by saying “We shall see.” His utterance implies that his situation is not stable and that he may not be able to cope with the pain in the future.

**Exemplar 10: YNI; response – not answer.** Exemplar 10 highlights P giving a response to the supervising physician’s (SP) YNI, but not answering or addressing the question.

Earlier in this consultation, the physicians discussed with P his report of pain on his ESAS form for this visit. That conversation involved talk about the amount of medication he is taking and the frequency with which he is taking the medication. The talk transitioned to a conversation about the ways in which the pain is impacting P’s everyday life (e.g., his weekend visits with his son) and his current quality of life. Just prior to Exemplar 10, SP and P discuss some of the ways in which P’s life has changed since his divorce from his wife. In Lines 1 to 4, P highlights that now he has more freedom to come and go as he pleases; consequently, he has “no problem” (Line 4).

![Exemplar](C8P4: 604-747)

1 P: Nobody can tell me >where you don’t go there,
2 you don’t go there:. I go where I want (go from).
3 (1.8)
4 *So* no problem?,
5 (2.7)
6 SP: *hmm
7 (0.2)
8 SP: → ARE You happy with where your pain control is now.
9 (1.3)
10 P: → U::h:
11 (0.7)
12 SP: Or could it be better?,

139
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

13  (1.0)  P: ↑\text{think} #very yeah it's okay#.  
15  (1.2)  SP: \text{•hh pt You're SITting a <little> bit more comfortably.}  
17  (1.0)  P: \(\text{•hh hh >Maybe because of the< radiat(hh)tion=}  
19  \text{SP:} \text{•hh hh}  
20  \text{P:} \text{•hh hh \text{[I g(hh)uess(h)} •hh hh \text{Huh-huh-y(h)eah(h)<.}}  
21  \text{•hh hh}

\text{Question.} SP’s YNI in Line 8 marks a topic shift. That is, she shifts the topic from P’s lifeworld issues to the management/control of his pain at the current time (“now”). The topic agenda of SP’s question is P’s level of satisfaction with his current state of pain control. SP’s question presupposes that P: (a) has pain; (b) is taking medication to control his pain; and (c) is able to evaluate his level of satisfaction with his current state of pain control. The grammatical design of SP’s question prefers a \text{yes}-type answer. SP’s question displays the principle of optimization (see Heritage, 2002; Heritage & Clayman, 2010; Stivers & Heritage, 2001): the question is designed so that the preferred answer confirms the positive outcome that P’s pain is controlled to his satisfaction. Although the design of the YNI encourages elaboration, the optimization of the question discourages elaboration.

\text{Response.} There is a long pause of 1.3 seconds after SP’s question; she remains silent and appears to wait for P to produce an answer (see Heritage & Clayman, 2010). P’s elongated “U::h:” response, surrounded by lengthy pauses (1.3 seconds before; 0.7 seconds after), is a filler “uh” (see Rendle-Short, 2004). A filler “uh” usually indicates that a speaker is doing uncertainty. It allows P to hold the floor while he searches for an appropriate response (see Schegloff, 1982), and it offers a response but not an answer to SP’s question (see Rendle-Short, 2004). P’s filler “uh” after SP’s question indicates that he views something about SP’s question as problematic. That is, P: (a) finds the type of
action the question solicits inappropriate; (b) finds the topic of the question difficult to address; and/or (c) rejects at least one of the presuppositions inherent in SP’s question.

It is not possible to know at this point in the conversation which presupposition(s) P may be rejecting. However, it is probably the third. Given that P has: (a) previously reported both verbally and on his ESAS form that he has pain; and (b) informed the physicians that he is taking medication to control his pain, it is improbable that he would find either of these presuppositions problematic. Rather, it is plausible that P finds it difficult to evaluate his level of satisfaction with his current state of pain control. It is also possible that if P acknowledges that he is less than “happy” with the physicians’ pain management strategy it could occasion an offer of a medication increase or change from the physician, which is something that P has attempted to avoid at other points in the conversation. Alternatively, it may be that he rejects the optimized design of the question and he is unwilling to characterize himself as “happy” with his current state of pain control, but reluctant to produce the dispreferred answer of no (or similar token), which may imply less than optimal care on the part of the doctor.

The likelihood that P finds the optimized design of the question problematic is supported in the talk subsequent to P’s “Uh” response (Line 7). Specifically, P’s response of “Uh” does not align with SP’s question and it does not include any lexical content through which SP can align with P in her next turn, thereby resulting in an interruption in the progressivity of talk. SP orients to possible issues with the question and its effect on progressivity (and that P is perhaps finding it difficult to respond to her YNI in Line 8) by producing a retrospective alternative question (ALT-Q) when she starts her next turn in Line 12 with “Or.” The “Or”-preface signals to P that what comes next (“could it be
better?”) is an alternative to her previous question. P’s answer of “I think very yeah it’s okay” to SP’s question in Line 12 responds to both of SP’s YNIs (Lines 8 and 12), replacing SP’s descriptors of “happy” and “better” with the weaker descriptor of “okay.” P’s answer provides a somewhat positive evaluation of the physicians’ pain management plan without fully endorsing it but leaving open the possibility for improvement. SP accepts P’s modest evaluation when she changes the topic in Line 16 to P’s current level of physical comfort while he is sitting in the chair.

**WH-Questions**

WH-questions (WH-Qs) are questions that ask *who, what, where, when, why* or *how*. WH-Qs are considered open-ended questions and “are seen as encouraging patients to respond in their own terms and permitting the emergence of narratives based on lifeworld experience” (Boyd and Heritage, 2006, p. 157). However, Heritage (2002) states that “not all wh-questions are equally open” (Heritage, 2002, p. 68). Generally speaking, *what, why* and *how* questions are more open because they encourage more elaboration than *who, when* and *where* questions. The design of WH-Qs makes relevant a specific type of answer (Schegloff, 2007). For example, *who* questions make relevant a person or people reference as an answer, *where* questions make relevant a place or position reference as an answer, etc. However, because WH-Qs are open-ended they do not demonstrate a bias or preference for a specific answer.

Currently, there are only a few studies that examine the use and the function of WH-Qs. For example, Heritage (2010) mentions the possibility of a respondent conforming to the action agenda of a WH-Q (i.e., providing the sought-for type of information made relevant by the WH-Q such as a time for a *when* question), but not to
the topic agenda. For example, a physician may ask a patient about her mother’s cancer with “Where was her cancer?,” to which the patient answers “Well, she lived in Arizona.” In this instance, the patient offers a location, but it is a geographical rather than a bodily location (Heritage, 2010).

Fox and Thompson (2010) discussed two main types of WH-Qs: telling and specifying. Telling questions seek extended or elaborated answers (reports, stories, accounts, etc.) from respondents, for example, “What has been happening with the pain in your back since your last visit?” In contrast, specifying questions seek specific pieces of information from the respondent and the patient is encouraged to answer in a concise manner with little elaboration, for example, “On what day did you first feel the pain in your back?” Fox and Thompson (2010) focused their analysis on the answers to specifying WH-Qs in American English conversations. They found that answers that provide the sought-for information (i.e., are type-conforming) are either given as a phrase (i.e., an answer that is limited to a grammatical phrase, e.g., ten miles) or as a full clause (i.e., contain the appropriate phrasal answer and also contain additional units of talk). Phrasal answers indicate that the respondent views the action and topic agendas of the question and the presuppositions inherent in the question as acceptable. In contrast, the additional talk in full-clausal answers “indicate some trouble with the sequence. Through their clausal form they may treat the question as inapposite in some way or may suggest that the answer is in some way not straightforward” (Fox & Thompson, 2010, p. 138).

For example, Q: “When is the surgeon going to operate on your knee?” A: “He’s going to

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52 Button and Casey (1985) refer to a telling question as an “itemised news enquiry” (Button & Casey, 1985, p. 5): a question that enquires about a specific newsworthy event. According to Button and Casey, itemised new enquiries are “requests to be brought up to date on developments concerning an ongoing recipient-related activity or circumstance, and are oriented to finding out about the latest developments, the latest news about the activity or circumstance” (Button & Casey, 1985, p. 8).
replace my ankle joint on Tuesday.” The respondent’s full-clausal answer contained the
appropriate phrasal answer (“Tuesday”), as well as a correction that rejects an inherent
presupposition in the question (i.e., that the respondent is having knee rather than ankle
surgery).

Stivers (2010) examined the question-answer system in American English talk.
She found that WH-Qs were asked only 27% of the time as compared to polar questions,
which were asked 70% of the time. What questions were the most common WH-Qs used
and they were used to inquire about prior talk, objects and events. How questions were
the second largest category of WH-Qs and they mostly involved “inquires about
personal/event states” (Stivers, 2010, p. 2775). In the present data set, the palliative care
physicians used WH-Qs nine times: four how questions, three what questions, one where
question, and one when question.

Since the action agenda of the physicians’ WH-Qs is the same for all the
exemplars in this section, the analysis with respect to the action agenda reported in this
section is confined to P’s answers to questions and whether or not his answers conform to
the action agenda of the question. Further, as in the YNI/YND section, the analysis of
epistemic stance of the physicians’ questions and P’s next turn answers is similar to the
analysis outlined in Chapter 253; therefore, the exemplar analyses in this section will not
address epistemic stance except where there are variations from the basic pattern.

**Exemplar 11: How question; delayed, type-conforming answer plus an account.**

Prior to Exemplar 11, R3 and P are introduced by SP. SP leaves the room and R3 begins

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53 By virtue of asking a question that seeks information, a speaker positions himself/herself in a relatively
unknowing (K-) epistemic stance in relation to a projected knowing stance (K+) of the respondent for the
topic being discussed (Heritage, 2010).
the consultation by informing P that they “can start from what’s been going on since your last visit” (Lines 1 to 3). P displays agreement with R3’s direction for the consultation via an affirmative head nod (Line 4).

(11) [C8P2: 37-116]

1 R3: U:m: we can just start from:
2 (0.2)
3 what’s been going on since your last visit.
4 P: (Nods head up and down)
5 (0.7)
6 R3 → U:mm: so couple things I wanna know is how is your pain.
7 (1.3)
8 P: → U:m
9 (2.0)
10 I still have pain.
11 (0.5)
12 Yeah.
13 (1.5)
14 U:mm
15 (0.3)
16 but I having better that it’s stopped growing in
17 my: ah: my pelvis.
18 (0.2)
19 Cuz I had radiation.
20 (1.0)
21 R3: [Excellent].
22 P: [ I:- I ] can feel it how: it was growing before.
23 (0.7)
24 I felt how it was growing before.
25 (0.5)
26 Ah: so I I couldn't sleep.
27 (1.0)
28 Ah:
29 (0.2)
30 had to: um?
31 (0.6)
32 wake up
33 (0.8)
34 you know
35 (0.3)
36 m: make some exercises ah: during the night?
37 (0.3)
38 before?
39 (0.6)
40 But now: I can sleep better
41 (0.3)
42 why I sink
43 (1.0)
44 um:
45 (0.7)
46 it stopped
47 (0.5)
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

Question. R3’s WH-Q in Line 6 is so-prefaced, which connects it to her previous statement in Lines 1 to 3. In Line 3, R3 sets the time frame for P’s answer as the period “since your last visit.” Also, R3’s WH-Q is prefaced by a pre-sequence (see Fox & Thompson, 2010) “a couple things I wanna know” that indicates to P that she is going to ask about more than one thing and probably two things (the standard understanding of a “couple”). R3’s how question is a telling question and is non-specific with respect to aspects of pain (i.e., the speaker does not specifically identify an aspect of pain to be addressed). Asking a non-specific question about aspects of pain provides P with an opportunity to talk about the features of his pain that are most salient to him (see Clemente et al., 2008). The design of R3’s question presumes that P has something to report about his pain. The topic agenda of R3’s WH-Q is P’s experience of his pain since his last visit. The presuppositions inherent in R3’s WH-Q are that P: (a) has pain; and (b) is able and willing to describe his pain.

Answer. The lengthy pause of 1.3 seconds after R3’s question indicates that P finds something problematic about R3’s turn. P’s delay in answering may reflect his waiting to see if R3 is going to pose the second question her turn indicates, rather than indexing a problem with the WH-Q. Once it becomes evident to P that R3 is not going to
add anything to her question, he produces a full clause answer (see Fox & Thompson, 2010) that consists of five-parts: He (a) conveys to R3 that he still has pain; (b) confirms that this is the case (“Yeah”); (c) reports that his pain is better than it was previously; (d) attributes the improvement in his pain to the radiation treatments (effects of treatment); and (e) provides an account for why he believes the radiation treatments have halted the growth of his tumour in his pelvis (site and effects of treatment) (i.e., he was having trouble sleeping before the treatments but after the treatments he sleeps better). P’s answer conforms to the action and the topic agendas of the question by providing R3 with the sought-for detailed account of his experience of pain since his last visit to the Clinic. Further, P’s answer accepts all the presuppositions inherent in R3’s question.

An interesting feature of P’s answer is that after his claim that he still has pain (Line 10), P provides a narrative that builds a context within which his claim of pain can be heard. Specifically, P prefaces his next TCU with “but” (Line 16), which proposes a relationship between his TCU in Line 10 (“I still have pain”) and Lines 16/17 (“I having better that it’s ((his tumour)) stopped growing in my pelvis”) by setting off the utterance in Lines 16 to 17 against that of Line 10. That is, P’s talk subsequent to the but-preface works to play down his admission of pain via his assessment that his pain has improved. P offers several pieces of evidence as support for his claim that his pain is better: (a) he had radiation, (b) he felt the tumour growing before the radiation, (c) the pain from the growing tumour would wake him up at night and he had to do some exercises to help relieve the pain, and (d) since having the radiation he can sleep better. Also, P reiterates that the tumour has stopped growing (Lines 42-46) (using the pro-term “it” to refer to the tumour in Lines 16, 22, 24 and 46), which discursively constructs his cancer as stable
(i.e., unchanged since his previous visit). The second time he says the tumour has stopped growing he hedges his claim with the epistemic marker “I think”. He then adds “at least stop,” which implies that at the very best his tumour might have shrunk and he might be getting better. P’s narrative answer exhibits troubles-resistance and shows stoicism.

Another interesting feature is the design of P’s answer in relation to the design of R3’s question. That is, in R3’s question, P’s pain is the subject of the question “how is your pain?”, whereas P’s answer shifts the subject from pain to P’s control over the pain, “I still have pain...but I having better,” rather than saying “My pain is still there but is better.” P’s ownership term “I” displays a sense of agency that demonstrates that he has the pain; the pain does not have him.

**Exemplar 12: What question; delayed, deferred, type-conforming answer.** As in Exemplar 11, R3’s WH-Q is prefaced with a contrast question and P produces a delayed, deferred, type-conforming answer. What is different in Exemplar 12 is that with the contrast question R3 sets a contingency on P’s answer and P attempts to reformulate R3’s question before he provides his answer.

Prior to Exemplar 12, R3 asked P about his experience of physical pain. In Lines 1 to 3 of Exemplar 12, P explains to R3 that after the latest round of radiation treatments, he noticed that his experience of physical pain (referenced by the pro-term “it,” which connects his turn to the previous talk) was different (Lines 1 to 3). R3 attempts to pursue some additional information about P’s experience of pain (referenced by labelling P’s pro-term “it” as pain [Line 5] and then with the repeat of the pro-term “it” in Line 7), but P begins his turn (Line 8) in overlap with R3’s “it.” In Line 8, P also uses the pro-term “it,” but in this instance “it” refers to the tumour in his pelvis. R3 cedes her turn (leaving
her question incomplete) and P continues his narrative (Line 8). As in Exemplar 11, P presents several pieces of evidence to support his claim that his experience of pain has changed: (1) the tumour “was” (past tense) growing and pressing on his nerves (Line 9); (2) his legs “were” (past tense) getting weaker because the tumour was pressing on his nerves (Lines 17 to 23); and (3) “now” (present tense) his legs are better; consequently, he believes the tumour is not pressing on his nerves (Lines 30 to 34), which has resulted in a change in his experience of pain.

(12): [C8P2: 137-272]

1   P:  [After] the radiation it
2   (0.7)
3   became different because of the radiation.
4   (2.2)
5   R3:  So before the <pain>
6   (.)
7   maybe you can tell me like a-a- is [it]
8   P:                                     [It] was growing.
9   It was growing and pressing my nerves.
10  (0.2)
11  R3:  Okay.
12  (0.5)
13   Okay.
14  (0.4)
15  P:  And ah:::::
16  (0.4)
17   so:::?:, I was feeling how:: my
18  (0.3)
19   my legs were
20  (.)
21   <weaker>
22  (0.5)
23   cuz ah::: of::n:- it was pressing my nerves,
24   ah:: the nerves go there.
25  (0.3)
26  R3:  Right.
27  (0.6)
28  P:  An so:::?:ah::::?:
29  (0.3)
30   I see now that my::: maybe my legs ar[:::e]
31  R3:  [^Hm^] ["better now, so I:: think >it is not<
32  (0.3)
33   pressing on my nerves.
34  (0.5)
35  R3:  I [understand].
36  P:  ["as much "]. That's why I [wasn't],
37
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

38 R3: [ Okay ].
39 (0.6)
40 R3: → And so INstead of the having the pa:in: pressing on your nerves what's the pain feel like now?,
(2.4)
41 P: → Now:ah ho-how i-it's like PREsent ah-i-i-
42 [it's present]
43 R3: [It's just the]r:e.
44 (0.4)
45 P: It°°-ju-it's there ye[ah (               )]
46 R3: [Okay. And is the pain] a-
47 (.)
48 P: >Not not< the::: it's not worse no.
49 (0.3)
50 R3: It's not worse.
51 (.)
52 Okay.

Question. In Line 40, R3’s WH-Q is prefaced with both “And” and “so” which links it to the previous talk. Before asking her what question, R3 produces a condition that specifies a contingency or pre-request (see Fox & Thompson, 2010) on the topic agenda of the upcoming WH-Q. That is, R3’s prosodic stress on “INstead” indicates to P that what is next (“of the having the pa:in: pressing on your nerves”) is not what she expects P’s answer to contain. As well, this YND gist formulation shows familiarity with P’s prior talk. That is, she connects her question with his prior talk via the partial modified repeat “pressing on your nerves.” However, she attributes P’s pain to pressure on his nerves, rather than to the tumour growth (Line 9).

After setting up the contingency on P’s answer, R3 asks a telling question (see Fox & Thompson, 2010) that is non-specific with regard to aspects of pain (“what's the pain feel like”), and that has a time aspect (“now”) tagged onto the end of the question. The topic agenda (highlighted through the prosodic stress on “pain” and “now”) is P’s present experience of pain. The presuppositions inherent in R3’s WH-Q are that P: (a) had pain in the past and that he currently has pain; (b) is able to make a comparison
between what his pain felt like before and what it feels like now; and (c) is able to articulate his current feeling of pain.

**Answer.** There is a lengthy pause of 2.4 seconds after R3’s WH-Q (Line 42). When P answers he begins by attending to the time limit set by R3’s question (i.e., his answer is about his current experience of pain) by saying “Now:ah.” But P abandons this turn beginning and he defers his answer with an attempt to transform R3’s question from a *what* question to a *how* question (“ho-how i-”). P abandons this restart as well. Finally he answers in a type-conforming fashion by describing his pain as something akin to or “like PREsent,” then in a definite manner “it’s ((his pain)) present” (Lines 43 and 44).

Although P provides a type-conforming answer his answer is non-specific in that he does not specifically identify any aspects of pain in his talk (beyond the partial repeat “Now” to indicate the same time aspect as R3’s question). As in Exemplar 6, P’s answer shows how difficult it can be to articulate the nature of a personal experience of pain.

**Given that P provides a type-conforming answer, he indicates to R3 that he ultimately accepts the topic and action agendas of her question and the inherent presuppositions. However, the lengthy pause before P starts his turn, the two false starts to his answer, and the attempt to transform R3’s *what* question to a *how* question indicate that P finds something problematic about R3’s question. It may be that what P finds problematic is the action agenda of R3’s question (i.e., the constraints imposed by the format of the *what* question). As indicated in the WH-Q section of Table 2, P is usually asked to elaborate on his experience of pain via a *how* question (e.g., “How is your pain after this last chemo session?” Excerpt #40), rather than asked to describe *what* his pain feels like. In this instance, *what* makes relevant an answer that includes adjectives or
descriptors such as sharp or achy (quality), worse (severity), out of control (management/control), and this question design discourages elaboration regarding such information as the site(s) and occasion(s) of his pain(s). According to Button and Casey (1985; see also Robinson, 2006), How are you feeling?-type questions are the usual format for specifically enquiring about the experience of “troubles which recipients are known to have” (Button & Casey, 1985, p. 8).

In Line 45, R3 summarizes P’s answer in Lines 43 and 44 with the gist formulation YND “It’s just there” (the pro-term “it’s”, referring to the pain, connects R3’s gist formulation to P’s prior talk). The word “just” works to downplay P’s description of his pain (i.e., “just” diminishes the importance of this experience of pain). Also, R3’s YND positions her in a less K- epistemic stance (i.e., more knowledgeable than if she asked a YNI or WH-Q, but less knowledgeable than P) (see Heritage, 2010). In reply to R3’s gist formulation, P begins to produce a full repeat of “It’s just there,” but he abruptly halts after “I°t°-” and “ju-” and he performs a self-initiated, self-repair with the partial modified repeat “it’s there.” P’s modified repeat that explicitly excludes “just” works to: (a) reject R3’s use of the minimiser “just”; (b) upgrade R3’s downgraded gist formulation; and (c) position P as more K+ (i.e., significantly more knowledgeable than R3) with regard to the way in which his experience of pain should be described (i.e., P disaligns with R3’s word choice that diminishes the importance of this experience of pain). P follows his answer with “yeah,” which indicates that the modified repeat is the appropriate description of his experience of pain. R3 accepts P’s greater K+ epistemic stance with “Okay” (Line 48) before she attempts to pursue further a description of P’s experience of pain.
Exemplar 13: When question; delayed, deferred, type-conforming answer plus repeat. Prior to Exemplar 13, P tells R5 that he usually experiences pain in his pelvis. In Line 1 of this exemplar, R5 asks P if this is a new pain. P answers “maybe it is not a new pain” (Line 5) because he has a tumour in his pelvis. R5 enacts alignment by acknowledging receipt of this information with “Yeah” (Line 8). P continues his account and informs R5 that right now he only feels the pain sometimes and that he does not consider it to be serious (Lines 12 to 14). R5 acknowledges receipt of this information with “Okay” (Line 16). She then produces the YNI “do you feel it occasionally” that is transformed into a gist formulation with the tag phrase “you said” (i.e., references P’s previous talk). The addition of the tag phrase repairs R5’s original YNI (which asks for information that P provided in Line 12) to a YNI gist formulation of P’s previous talk. P confirms R5’s gist formulation with a partial repeat (“occasionally”).

(13): [C17P2: 313-401]

1  R5: Is that a \text{new pain}?
2    (0.7)
3  P: Ah:::
4    (1.3)
5      maybe it is not a new pain no. Because I have also
6      tumour here.
7    (0.3)
8  R5: Yeah.
9    (0.4)
10 P: So::
11    (.)
12    that's why sometimes I::: but °hm:::°
13    (0.7)
14    right now it is not \text{serious} °or something like no°.
15    (0.3)
16  R5: Okay.
17    (0.4)
18  P: U::m:
19    (0.2)
20    do you >feel it< \text{occasionally you said}.
21    (.)
22  P: [ Occasionally ].
23  R5: \text{[When when when] do you notice it}.
24    (0.9)
25  P: \text{When?: I always notice it}.
26    (0.7)
It's alwa- [you always]<=
[  Always  ]
=feel it there.
(0.2)
P: Y:eah:: sometimes yeah but ↑[ah::]
R5: [Okay].
(0.5)
P: °°jus°°
(0.3)
R5: Does anything make it better?
(1.1)
P: U::m
(1.9)
no >I don't< nee:d ah:: I think anything for this.
(0.8)
Cuz I usually take oxyconton.
(.)
R5: Uh huh.=
P: =Ten milligrams
(0.3)
°°you know°°.

Question. R5 pauses for only a micro-second after her gist formulation YNI in Line 20 before she moves to a new sub-topic (a time when P notices his pain) via a WH-Q (Line 23). R5’s quick movement from a YNI to a WH-Q results in R5’s WH-Q being produced in overlap with P’s answer of “occasionally” to her YNI. R5 repeats the word “when” three times in overlap with P’s confirmatory turn in Line 22 before she continues her turn unimpeded. R5’s repetition of “when” in overlap displays (a) a sensitivity to her violation of the conversation turn-taking norm of “one party talking at a time” (see Sacks, 2004, p. 37); and (b) her efforts to continue occupying the turn space that started in Line 20. R5’s WH-Q is a specifying question that requires a simple, concise answer (see Fox & Thompson, 2010) relevant to either a time or an occasion that P notices or perceives the pain in his pelvis (topic agenda). The presuppositions inherent in R5’s question are that: P (a) feels the pain in his pelvis occasionally; and (b) is able and willing to report the specific time(s) or occasion(s) when he notices the pain.
Answer. There is a lengthy pause of 0.9 seconds before P produces a type-conforming answer that is deferred by a repeat of R5’s “when.” The rising final intonation of P’s repeat of “when” indicates that he views something problematic about R5’s word choice. Also, P’s full clausal answer to a specifying question rather than a phrasal answer indicates trouble. Although P identifies a trouble source in R5’s previous turn (i.e., “when”), he does not pause to give R5 an opportunity to initiate a repair before he completes his turn with a type-conforming answer. P demonstrates with his answer that he: (a) accepts the topic and action agendas of R5’s question; (b) accepts the inherent presuppositions; and (c) disregards the time and occasion aspects of his perception of pain by only addressing the frequency of his perception of pain (always).

An interesting feature of P’s turn is that he makes the distinction between when he is feeling the pain (“occasionally,” Line 22), which was his answer to R5’s YNI in Line 20, and when he notices the pain (“I always notice it”) with the use of prosodic stress on “always” and “notice.” P’s distinction between feeling and perception highlights that his pain occurs intermittently (i.e., “sometimes” – Line 12) and that he feels the pain at these times. Further, when he feels the pain he “always” (Line 25) notices the pain. R5’s assertion in Lines 27 and 29 “It’s always you always feel it there” shows that R5 treats P’s report of feeling pain and noticing pain as equivalent. P’s reply in Line 31 “Yeah sometimes” further displays his distinction between feeling and perception via a reiteration of “sometimes” (Line 12) in relation to his feeling of pain. R5 acknowledges P’s answer of “sometimes” with “Okay” (Line 32) and she moves onto another sub-topic of possible actions that improve his experience of pain (“Does anything make it better?” – Line 36).
Exemplar 14: How question; response but no answer. This exemplar is an example of a how question that asks P for a telling, and which is followed by a response to the question, but not an answer. Talk subsequent to the bolded Q/A-AP in Exemplar 14 shows that R2 does not treat P’s response as an answer because she pursues the topic with a YNI (for details see Exemplar 5).

Prior to Exemplar 14, R2 asks P why he reported on his ESAS form that he is experiencing more fatigue since his last visit to the Clinic. P attributes the increase in fatigue to taking the prescribed medication. In Line 1 of this exemplar, R2 asks P how much medication he is taking. P tells R2 the amount of pain medication he is taking (Line 2).

(14) [C6P2: 298-363]
1   R2: And how much of the medication are you currently taking?=
2   P: =Ah two pills of oxycotton ten milligrams.
3   R2: → And how is that helping your pain?
4     (0.7)
5   P: → ↑ Ah it's → ah yeah
6        (0.2)
7     it's::: >more or less< okay yeah.
8     (0.6)
9   R2: So when you take the medication
10     (0.3)
11   do you have relief?
12   P:   (1.2)
13     °Hm:*°
14     (0.4)
15   Yeah.
16     (0.5)
17   It's::: 
18     (0.9)
19   Yeah
20     (0.4)
21   I have relief.
22     (0.4)

Question. In Line 2, R2’s and-preface to her WH-Q links this question to the previous talk about the pain medication that P is taking. R2’s how question sets the action agenda required of P within the broad limits of providing R2 with an extended or
elaborated telling (or a report) of the ways in which the pain medication is (or is not) influencing P’s experience of pain. The topic agenda of R2’s question can be interpreted in one of two ways: as (1) a subjective evaluation of the perceived effectiveness of the pain medication (effects of treatment); or (2) a technical description of the ways in which the pain medication is working to relieve his pain (e.g., the medication enters his bloodstream and it targets the pain area, working to block the pain receptors to the brain). The presuppositions inherent in R2’s question are: (a) P has pain; and (b) P is taking the prescribed pain medication as evidenced by the preceding talk and R2’s use of the pro-term “that.”

Response. P waits for 0.7 seconds before responding “↑Ah it's ↓ah yeah (0.2) it's::: >more or less< okay yeah.” P’s utterance provides a response to the question but it does not provide the sought-for telling or report, which would include a description of the ways in which the pain medication is influencing his experience of pain. Rather, P provides a delayed, non-committal response that is non-specific with regard to the aspects of pain. That is, the pro-term “it” refers to his pain and he informs R2 that his pain is “more or less okay.” This response addresses only part of R2’s question (i.e., his pain is passable) because P does not credit the medication for his pain management.

P’s response indicates that he finds something about R2’s question problematic. It is possible that the ambiguity in the topic agenda of R2’s question contributes to P’s problem with producing an answer. After a 0.6-second pause, R2 shows that she does not accept P’s response as an answer because she reformulates her WH-Q to a YNI (Lines 9 to 11), while still enquiring about the effects of treatment. As stated in the analysis of Exemplar 5 (Lines 9 to 21), P produces a preferred, type-conforming answer to R2’s
YNI; however, the lack of sufficient specificity regarding the term “relief” appears to be problematic for P and R2 reformulates her YNI to an ALT-Q (for a detailed analysis of the ALT-Q Q/A-AP see Exemplar 16).

**Alternative Questions**

In various literatures, alternative questions (ALT-Qs) are also known as “nexus questions, closed questions, choice questions, either-or questions and multiple choice questions” (Nordquist, 2011, p. 2). ALT-Qs offer the respondent a set of possible answers in the form of two or more alternatives, and usually include an explicit direction (e.g., do you want) to the respondent to choose among the provided choices (Koshik, 2005; Nordquist, 2011; Stivers, 2010). The action agenda of ALT-Qs calls for a repetition of one of the proffered alternatives (i.e., a type-conforming answer). An example of an ALT-Q is “Do you want the blue ball or the red car?” In this example, the speaker provides the respondent with two items to consider (“the blue ball” and “the red car”). By placing “or” between the two options, the speaker grammatically presents the two items as exclusive. That is, the respondent can choose either the blue ball or the red car, but not both. The direction to the respondent to choose between these two options comes in the form of “Do you want.” “Do you want x or y” is one of the three forms that ALT-Qs most commonly take (McCawley, 1998). The other two forms are: “Do you want the blue ball, or would you rather have the red car?” and “Which toy would you like to have, the blue ball or the red car?” Typically, ALT-Qs are used to provide a respondent with limited answer choices (McCawley, 1998; Nordquist, 2011). According to Koshik
ALT-Qs can also be used for other-initiated repairs\textsuperscript{54} and error corrections\textsuperscript{55}.

ALT-Qs that are used to provide a respondent with a choice do not demonstrate a particular preference for one option over the other (Bolinger, 1957, as cited in Koshik, 2005). Bolinger states that if the speaker had a preference for one option over the other, it is unlikely that the speaker would mention the dispreferred option at all. Koshik (2005) supports this stance for ALT-Qs used to offer a choice or to initiate repair, but she argues that ALT-Qs “do exhibit a preference for one alternative over the other...when they are...heard to be doing error correction, i.e., proffering one alternative, the second one, as a candidate correction of an utterance targeted in the first alternative”\textsuperscript{56} (Koshik, 2005, p. 203).

The use of ALT-Qs is not common in everyday or institutional talk (Koshik, 2005; Stivers, 2010). Currently, there are only a few studies that examine the use and the

\textsuperscript{54} ALT-Qs can be used to initiate repair by identifying a trouble source in the previous talk (Koshik, 2005). The trouble source can be a matter of either hearing or meaning. That is, the respondent can use an ALT-Q to indicate that he/she heard something but he/she is not sure what was heard (e.g., Did you say bowl or bone?), i.e., to request clarification of what was said. Or a respondent can indicate that he/she heard something but is unsure what was meant by what was said (e.g., When you say that they came after you, do you mean they were chasing you or that they followed you into the room?), i.e., to request clarification of what was meant.

\textsuperscript{55} ALT-Qs can be used to initiate error correction when the respondent does not agree with something the speaker said (Koshik, 2005). That is, the respondent can identify the trouble source in need of correction by repeating it as the first option in an ALT-Q and by offering a candidate correction for the second option (e.g., A: He inferred he was going, B: Inferred or implied?).

\textsuperscript{56} Koshik’s (2005) research is based on ALT-Qs used in ordinary conversations and in teacher-student interactions. She does not discuss the use of ALT-Qs in a medical context. This is important to note because in Koshik’s research she talks about candidate corrections as \textit{information-giving} not \textit{information-seeking}. That is, in a teacher-student interaction the teacher uses an ALT-Q as an \textit{information-giving} tool (i.e., a way of conveying the teacher’s predetermined correct answer to the student by first stating what the student said and then offsetting that with a correct alternative). ALT-Qs in this context are known answer questions. When discussing patients’ subjective experiences in a medical context, a physician is not privy to a patient’s personal experiences, thoughts, hopes etc., so using an ALT-Q in this context is for \textit{information-seeking} purposes and error correction is not relevant. The difference between \textit{information-giving} and \textit{information-seeking} also involves issues of epistemic stance. That is, in teacher-student \textit{information-giving} situations, the teacher is K+ (has more knowledge than the student about the topic of the ALT-Q) and the student is K− (has less knowledge than the teacher about the question topic). In physician-patient \textit{information-seeking} situations where the physician is using an ALT-Q to elicit information from the patient, the physician is K− in relation to the patient’s greater K+ epistemic stance.
function of ALT-Qs. For example, Stivers (2010) examined the question-answer system in American English and she found that, of the 350 question-answer sequences occurring in her data, ALT-Qs were used only three percent (n=8) of the time, as opposed to polar (yes/no-type) questions, which were used 70% (n=230) of the time. Research by Brown (2010) found that of the 419 question-answer sequences occurring in her data of talk in a Tzeltal (Mayan) community, ALT-Qs were only used one percent of the time (n=4) in comparison to polar questions which were used 74% (n=23) of the time. The scarcity of the use of ALT-Qs in talk is reflected in the present data: the palliative care physicians used ALT-Qs eight percent (4 of 49 questions) of the time. In contrast, polar questions occurred 73% (n=36) of the time.

Since the action agenda of the physicians’ questions is the same for all the ALT-Q exemplars in this section, the analysis with respect to action agenda reported in this section is confined to P’s answers to questions and whether or not his answers conform to the action agenda of the questions. Further, as in the YNI/YND and WH-Q sections the analysis of epistemic stance of the physicians’ questions and P’s next turn answers is similar to the analysis outlined in Chapter 2; therefore, the exemplar analyses in this section will not address epistemic stance except where there are variations from the basic pattern.

**Exemplar 15: ALT-Q used to initiate repair; type-conforming answer with no delay plus account.** Exemplar 15 is an example of an ALT-Q being used to seek clarification about the meaning of something that P said previously. P provides a type-conforming answer that includes an account describing what he means when he says his pain is “different.”
Just prior to Line 1 of this exemplar, R4 informs P that she has compared his symptom report (i.e., the ESAS) from this visit to the one he filled in at his last visit. In Line 1 she makes the assessment that his “pain seems to be stable” (Line 1). P answers “Yeah more or less” in overlap with R4’s reformulation of her assessment as “The same as last time” (Line 4). R4 then asks P where he is experiencing pain, first as a what question in Line 6 (to which P initiates a repair with a repeat of what with rising final intonation), then as “where” and finally as a what question that asks P to identify a specific part of his body (Line 10). In Lines 14 to 15 P reports that he usually has pain in his pelvis. P pauses for 0.8 seconds presumably waiting for some form of acknowledgement from R4. When none is provided, P continues his turn with a so-prefaced assertion that describes a new symptom: he is experiencing some “unusual feelin” on the outer sides of his legs and feet (Lines 17 to 20). R4 acknowledges receipt of this new information with “Uh huh” in overlap in Line 19 and “Uh hm” in Line 22.

(15) [C10P2: 123-230]

1  R4: The pain seems to be ah stable.
2 (0.2)
3 P: [↓Yeah: ↓more or less]
4 R4: [The same as °last] time°.
5 (1.3)
6  What is the pain?
7 (1.2)
8 P: What?
9 (0.3)
11 P: =Ah
12 (0.3)
13  (1.3)
14 P: it's usually in my pelvis and ah:: yeah it's usually in my pelvis.
15 (0.8)
16  (0.3)
17 So I have some like unusual feelin from the outer side
18 [of my legs]=
19 R4: [ Uh ’huh ]
20 P: °and my feet°.
21 (0.3)
22 R4: °Uh hm°. °↓hh And when you say unusual is: it is:
23 more painful or is
feel different?,
not normal feelin, because here for example is everythin
Normal as it was before [the cancer].

P: But here it's: it's: something like
different. Different,
Yeah ah-ah usually I don't: feel it: when >I I<
when it is not touched.

But when you touch it's different.

P: Uh hm.

"pt" hh Ah:::
Okay it's both legs::?
P: B-both legs but more
more the right one.

R4: Especially the right.

Question. R4’s Alt-Q in Line 22 begins with an “And”-preface and a reference to
P’s previous use of the term “unusual” (“when you say”) that links this question to the
preceding talk. These links to P’s previous talk set up R4’s ALT-Q as seeking
clarification of meaning. R4 identifies P’s use of the descriptor “unusual” as a trouble
source when she initiates repair on P’s turn by offering two possible definitions for
“unusual” (i.e., “painful” and “feels different”), opposing them with the word “or” and

\[\text{With respect to the word “more,” prior to “painful” in R4’s Alt-Q I interpret R4’s use of “more” as her way of setting up the alternative options of “painful” and “different.” This interpretation stems from the prior talk where R4 states that P’s report of pain on the ESAS is stable and P’s subsequent agreement with that statement. As well, P does not state that he has more pain when he indicates to R4 that he usually has pain in his pelvis, only that he has pain. Therefore, it is logical to assume that R4’s use of “more” is indicating to P that he consider whether the “unusual feelin” in his legs and feet can be described more accurately as “painful” or as “different.”}\]
thereby making relevant a self-repair in P’s next turn. R4’s question enquires about the severity and quality aspects of P’s experience of pain. The topic agenda which P’s answer should address is his use of the descriptor “unusual.” R4’s question presupposes that P: (a) has pain; and (b) is able and willing to describe his pain beyond his previous adjective “unusual.”

**Answer.** P’s answer: (a) conforms to the action and topic agendas (i.e., he repeats one of the answer options from R4’s ALT-Q); (b) accepts the presuppositions inherent in R4’s question; and (c) addresses quality and time aspects of his pain but not the severity. P provides an elaborated answer. In Exemplar 15, P’s answer highlights three contrasts: between (1) the “normal feelin” he has on the inside of his legs as compared to the “different” feeling he has on the outside of his legs and feet, (2) the feeling in his legs and feet before the cancer as compared with now; and (3) when his legs and feet are not touched as compared with when they are touched.

P’s elaborated answer indicates that he may view something about R4’s ALT-Q as problematic because it goes beyond the requirement simply to repeat one of the alternatives. Fox and Thompson (2010) argue that full clausal answers in WH-Qs indicate trouble with the sequence or that the answer is not straightforward. They do not address ALT-Qs, but it can be argued that an elaborated answer to an ALT-Q is similar to the full clausal answer to a specifying WH-Q. That is, simply repeating one of the two alternatives would be a sufficient answer to the question, in the same way that a phrasal

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58 The use of deictics and such gestures as pointing, touching, etc. assist patients with the description of the site and possible changes in their experience of pain (e.g., pain radiating from one area to another) (Heath, 1989). In the video we can see that P’s deictic “here” in Line 28 refers to the inside of his thighs (P runs his hands down this area) and in Line 32 “here” refers to the outside of his thighs (P runs his hands down this area).
answer is a sufficient answer to a specifying WH-Q and a yes- or no-type answer is a sufficient answer to a YND. P’s elaborated answer may indicate that neither of the two options provided completely capture the way in which P would define the “unusual” feeling he is experiencing in his legs and feet. That is, “painful” implies that the feeling on the outside of his legs and feet can be characterized the same as the pain in his pelvis, and “different” is an ambiguous answer. Given that (a) P makes the distinction between the pain (referenced by the pro-term “it” in Line 14) he feels in his pelvis (Lines 14 to 15) and the new “unusual” (Line 17) sensation on the outside of his legs and feet, and (b) he has not previously reported pain in his legs, it is reasonable to infer that the first option in R4’s ALT-Q is not an appropriate descriptor or he would have indicated that in Lines 14 to 15. It is possible that P chose the option “different,” and that he provided a subsequent explanation of how his pain is different, because R4’s descriptor “different” is pitched at the same level of ambiguity as P’s initial descriptor of “unusual.” P’s non-descript answer regarding the sensation in his legs and feet (beyond two ambiguous terms) is another example of the display of difficulty in articulating the nature of a personal experience and identifying a sensation as painful. R4 accepts P’s answer as adequate because she uses her next turn to request confirmation that both legs are involved.

**Exemplar 16: ALT-Q used to initiate repair: non-type-conforming response.**

Exemplar 16 is an example of an ALT-Q being used as a means to repair a potential trouble source in a previous turn. P provides a response to R2’s question, but the response does not answer or address R2’s question. Prior to the bolded Q/A-AP in this exemplar, R2 asks P if he has relief when he takes the pain medication (Lines 1 to 3). P provides a preferred, type-conforming answer (Lines 9 to 13) that displays that he finds something
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

problematic about R2’s question (see Exemplar 5 for a detailed analysis of the Q/A-AP in Lines 1 to 13).

(16) [C6P2: 298-363]

1 R2: So when you take the medication
2 (0.3)
3 do you have relief?
4 (1.2)
5 P: °Hm:*°
6 (0.4)
7 Yeah.
8 (0.5)
9 It's:::
10 (0.9)
11 Yeah
12 (0.4)
13 I have relief.
14 (0.4)
15 R2: °Okay°.
16 (0.4)
17 →•hh I mean-
18 (0.4)
19 does it get from like
20 (1.2)
21 >does it ever get down to< zero or do you always have
22 (0.3)
23 °pain°?
24 (0.7)
25 P: →Ah:::
26 (0.2)
27 I have pain more >when when< I am sittin'.
28 R2: Yes.
29 (.).
30 P: So::: I don't want to take a lot of pain
31 >medica-I don< want to take a lot of
32 (0.2)
33 chemicals.
34 (.)
35 [I have enough] chemicals so:::
36 R2: [ Ye:::ah ]
37 (0.6)
38 Okay.
39 P: The chemo.
40 R2: Are you using any of the break through pain medications?

Question. The topic agenda of R2’s question and the aspects of pain enquired about are the severity and frequency of P’s experience of physical pain (Lines 17 to 23). The I mean-preface indicates that R2 views something about her earlier YNI question
(Lines 1 to 3) as problematic and that she does not view P’s answer (Lines 5 to 13) to her YNI as adequate. Her pro-term “it” (referring to P’s pain) connects the turn in Lines 15 to 23 with earlier talk about P’s experience of pain (not shown), and with her YNI in Lines 1 to 3. R2’s self-initiated, self-repair in Lines 15 to 23 identifies the trouble source in Lines 1 to 3 as “have relief.” That is, R2’s ALT-Q reformulates her earlier YNI into a more specific question about the severity and frequency of P’s pain by providing P with meaning clarification for “have relief.” R2’s ALT-Q offers P two opposing extremes to choose from to describe either the severity of his pain (“ever get down to zero”) or the frequency of his pain (“always have pain”). The presuppositions inherent in R2’s ALT-Q are that P: (a) has pain; and (b) is able to evaluate the severity and frequency of his pain.

Response. P’s response does not conform to the type of action required by R2’s question (i.e., it does not include either of the options stated in R2’s ALT-Q, although it does address the severity of his pain on a specific occasion). It is not clear whether P is rejecting at least one of the presuppositions or the alternatives provided. If he is rejecting a presupposition, it is likely the second presupposition (that he is able to evaluate the severity and/or frequency of his pain), given that he spoke recently about having pain. Alternatively, it may be that he rejects both alternatives as inappropriate. This is a reasonable interpretation given that both alternatives are phrased as extreme case formulations (zero versus always).

It is also possible that P is rejecting the topic agenda. Determination of whether or not P’s response conforms to the topic agenda of R2’s question depends on how narrowly the topic is defined. That is, if the topic allows for specific references to the variability in the severity and/or frequency of P’s experience of pain depending on an occasion, then
P’s response is on topic and is just non-type-conforming. However, if the topic is more
generally about the variability in the severity and/or frequency of P’s experience of pain,
then P’s response about the variability of his pain depending on the occasion is not on
topic. If the latter situation is the case, then, as in Exemplar 9 P’s response is agenda-
transforming (see Stivers & Hayashi, 2010): it transforms the topic agenda of R2’s
question from the severity and/or frequency of his pain generally to a specific occasion
when he feels the pain with greater severity (“I have pain more when when I am sittin’”).

Examination of the talk subsequent to the Q/A-AP in Exemplar 16 shows that
R2’s answer of “Yes” in her next turn in third position (Line 28) aligns with P’s telling
and encourages him to continue his turn. P’s answer to R2’s display of alignment is to
state that he does not want to take a lot of medication (Lines 30 to 35), which R2
acknowledges with “Yeah” and “Okay” (Lines 36 and 38). This talk subsequent to
Exemplar 16 appears to demonstrate that R2 views P’s response in Lines 25 to 27 to be
on topic because she does not pursue a type-conforming answer to her ALT-Q; therefore,
his response might best be viewed simply as non-type-conforming and not as agenda-
transforming.

Questions in Multi-Unit Turns

Multi-unit questioning turns at talk occur more often in interviews (e.g., news
interviews, job interviews) than in ordinary conversations (ten Have, 2007). In an
interview there is an expectation and acceptance that an interviewer will ask questions
(Button, 1989, as cited in ten Have, 2007). An interviewer’s turn may also involve
different types of components, such as an announcement and an assertion or an
assessment that is followed by a question relevant to the preceding TCU(s) of the multi-unit questioning turn.

To date, there is no published literature regarding the use of multi-unit questioning turns at talk in medical encounters. In the present study, multi-unit questioning turns at talk are turns that involve more than one TCU and that contain at least one question assessing physical pain; they can also include assessments, announcements and/or assertions. There are seven multi-unit questioning turns in the present data set. The type of questions in the multi-unit questioning turns varies: YNI (4), YND (2), ALT-Q (2) and WH-Q (1). Five of the seven multi-unit questioning turns have been chosen as exemplars (see Table 3). As in the single-unit questioning turns, Q/A-APs were analyzed using the four dimensions of question design (Boyd & Heritage, 2006; Heritage, 2010). As well, the additional TCUs of the physicians’ multi-unit questioning turns were analyzed in relation to the Q/A-APs and some further analysis is provided at the end of this section.

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59 The literature on multi-unit turns at talk does not usually contain examples of turns with more than one question. In contrast to the standard multi-unit turns, the present data contain examples of multi-unit turns that have more than one question. Therefore, the number of multi-unit questioning turns is fewer than the number of questions incorporated in them.
Table 5: Multi-Unit Questioning Turns and Answers

<table>
<thead>
<tr>
<th>Excerpt#/Sequence #</th>
<th>Question Type</th>
<th>Question</th>
<th>Answer Type</th>
<th>Answer</th>
<th>Exemplar #</th>
</tr>
</thead>
<tbody>
<tr>
<td>49/15</td>
<td>Assertion/YNI</td>
<td>And from one to ten when ten is the worst pain so you (.) you describe that you were (0.4) having a tree. (0.2) Is that [correct]?</td>
<td>Preferred answer - Type-conforming</td>
<td>[Yeah] yeah.</td>
<td>17</td>
</tr>
<tr>
<td>50/16</td>
<td>Assertion/YNI</td>
<td>So:; it seems that the- the- the day (0.3) the- the pain during the da::y has been stable. (0.4) Is that [correct]?</td>
<td>- qualified +</td>
<td>(Y:eh:::ah: it’s it’s more or less &gt;yeah yeah&lt; stable even during the night. It’s stable [more or less].</td>
<td>17</td>
</tr>
<tr>
<td>51/18</td>
<td>WH-Q/YNI</td>
<td>And how is the pain now:: Is:: ah:: is:: that [bothersome::e &gt;after you stop it&lt;]</td>
<td>Preferred answer - type-conforming/No response</td>
<td>[Ah it’s more or less okay] ah::: more [or less]</td>
<td>18</td>
</tr>
<tr>
<td>46/9</td>
<td>YNI/ALT-Q</td>
<td>And is it an achy pain? (0.2) Is i:t (0.2) something that (0.5) is kind of always (0.2) always there?, Does it come and go::?:,</td>
<td>No response/Type-conforming</td>
<td>(0.2)</td>
<td>19</td>
</tr>
<tr>
<td>52/1</td>
<td>Assertion/ALT=Q</td>
<td>In FACT You ranked it as::: a little even bit better than the last time ar-around, &gt;do you think that that’s the truth?, &lt; or somewhere (hh)uhh probably about the same.=</td>
<td>Not type-conforming</td>
<td>=It could be yeah:::</td>
<td>20</td>
</tr>
<tr>
<td>53/4</td>
<td>Assertion/YND</td>
<td>&gt;And so&lt; your perception is that (0.4) the pain has been CONstant. It hasn’t (0.4) decreased or it hasn’t increased (0.2) in with this last session?=</td>
<td>Dispreferred answer - Type-conforming</td>
<td>=&gt;Yeah yeah it&lt; increased when: they began (the new) chemo?,</td>
<td>21</td>
</tr>
<tr>
<td>54/5</td>
<td>Assertion/asssertion/ assertion/ YND</td>
<td>When we look at your (0.3) your u::m: pt symptom assessment (.) report (0.5) u::m (.) your pain is constant. It was (0.2) two the last time, it’s two this time. (0.2) hhh U::m: (1.0) but you (.) seemed &gt;to have&lt; (0.3) &lt;been: more&gt; aggressively showing (0.6) ah::: just the symptoms were (.) a-or may be more so there the last time. &gt;That could&lt; just be:: (:) how you were drawing but, (0.5)</td>
<td>- Deferred</td>
<td>=&gt;I-I-I&lt; just ah::: (1.1) I just (0.2) u::: (0.2) draw the area more or less i-i-it does[n’t me]an that i-it intensity. Yeah.</td>
<td></td>
</tr>
</tbody>
</table>
**Exemplar 17: An assertion followed by a YNI; type-conforming, preferred answer.** In the bolded multi-unit questioning turn in Exemplar 17 (Lines 40 to 46), R4 initially makes an assertion that acts as an observation about P’s self-report of pain on his ESAS form for the current visit (Lines 40 to 44). The assertion is not designed to indicate clearly that a confirmatory answer is expected of P and R4 follows her assertion with an YNI. P provides a simple type-conforming, preferred answer.

Prior to Exemplar 17, R4 informs P that she has reviewed his ESAS responses for this visit. R4 makes the assessment that P’s pain currently seems to be stable. She asks P to identify where he is experiencing pain. P makes the claim that he usually has pain in his pelvis. Lines 1 to 26 are discussed in detail in Exemplar 15. In summary, P identifies a new symptom: an unusual feeling on the outside of his legs and feet. R4 pursues clarification of P’s descriptor “unusual.” R4 enquires if the unusual sensation is in both legs. P confirms the sensation is in both legs, but more in the right one.

(17): [C10P2: 123-230]

1  P: So I have some like unusual feelin from the outer side
2   [of my legs]=
3  R4: [ Uh  huh ]
4  P: *=and my feet*.
5  (0.3)
6  R4: °Uh hm°. °hh And when you say unusual is: it: is:
7   more painful or is
8  (0.3)
9  R4: °Uh hm°. °hh And when you say unusual is: it: is:
10  feel dif[ferent]?,
11  P: °[As  in] feel different ah::
12  (0.2)
13  not normal feelin, because here for example is everysing
14   Normal as it was before [the cancer].
15  R4: °[ Y:eah: ]
16  (0.5)
17  P: But here it's:- it's: something like
18   (0.4)
19  different.
20  (0.5)
21  Different,
22  (0.8)
23  Yeah ah-ah usually I don't: feel it: when >I I<
24  (0.5)
when it is not touched.

But when you touch it's different.

R: Uh hm.

°pt° •hh Ah:::

Okay it's both legs::?

P: B-both legs but more

more the right one.

R: Especially the right.

R4: And from one to ten when ten is the worst pain so you

you describe that you were

having: a tree.

→ Is that [correct]?

P: [Yeah ] °yeah°.

R4: How much oxyconton are you taking right now?

P: About six a day.

Multi-unit questioning turn. R4’s “And”-preface to the first TCU of her turn links this assertion (“And from one to ten when ten is the worst pain so you you describe that you were having a tree”) to the previous talk about P’s assessment (via the ESAS) of the severity of his pain (talk prior to this exemplar). R4’s pro-term “that” in Line 7 connects the two TCUs in R4’s turn. However, it is not clear whether “that” refers to the description or to the experience. Similarly, it is not clear whether the topic agenda is the accuracy of R4’s claim (that P did indeed describe his pain as a three) or the accuracy of P’s evaluation of his pain (as a three). The presuppositions are that P (a) has had pain; (b) has reported on his pain; and (c) can recall how he described his pain.

Answer. P’s type-conforming, preferred answer (first produced in overlap with the end of R4’s question and then again in the clear) demonstrates that P accepts the topic
and action agendas and the inherent presuppositions in R4’s YNI. However, it is not clear which topic P is accepting, but this is not a problem for the participants because R4 moves onto the next question.

**Exemplar 18: How question followed by a YNI; type-conforming answer to the how question, no response to YNI.** In the bolded Q/A-AP in Exemplar 18, R4’s multi-unit questioning turn begins with a how question that is quickly followed by a YNI. The quick succession of her two questions does not provide P with an opportunity to answer the first question before she asks the YNI. P provides an answer only to R4’s how question.

This exemplar begins with P providing R4 with the explanation that when he took the prescribed medication for nerve pain he experienced swelling in his legs (Lines 1 to 20). P then reports that he discontinued taking the medication. R4 offers a name for the medication (Line 22) and P gives a hesitant confirmation of “I think yes” (Line 24). P explains that when he was taking the medication his legs became increasingly swollen (Lines 27 to 28) and he reiterates that he discontinued the medication (Line 32). P adds that he will tell the supervising physician about the incident (Line 33). R4 asks P when he stopped taking the medication (Line 35), to which P replies, “About a week ago” (Line 37). In Lines 40 to 42, R4 summarizes P’s previous talk about why he discontinued the medication (i.e., because his legs were swelling) in the form of a YND. P provides the type-conforming, preferred answer of “Yeah” (Line 43). R4 informs P “we will discuss that” (Line 46). At this point in the conversation it is unclear if “we” refers to (a) R4 and P, (b) R4 and SP, or (c) R4, P and SP.

(18): [C10P2: 964-1033]

<table>
<thead>
<tr>
<th>Line</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>P: Ah: : : : :</td>
</tr>
<tr>
<td>2</td>
<td>(0.4)</td>
</tr>
</tbody>
</table>
I had something like medication against nerve pain.

R4: Gabapentin

P: Yeah.

R4: Swollen less?

P: So I discontinued it. I'll tell (the supervising physician) about this.

R4: When did you stop the medication?

P: About a week ago.

R4: And the main reason was because of the swelling: legs.

P: Yeah yeah yeah.

R4: =Okay.

P: [Yeah it's more or less okay] ah::: more or less]

R4: [Any changes]?

P: [No].

R4: "No changes right now".

P: =Okay.

R4: [Hm ]

P: would you able to lie down so I check i-the
Multi-unit questioning turn. R4’s “And”-preface to her _how_ question links this question to the previous talk about the swelling and pain in P’s legs. R4’s _how_ question is a non-specific question (with the time tag of “now”) that asks P for a telling (i.e., a full-clausal answer). The topic agenda of R4’s WH-Q is P’s evaluation of his pain at the present time. The presuppositions inherent in R4’s WH-Q are that P: (a) has pain; and (b) is able and willing to describe his pain. R4 quickly follows her WH-Q with a YNI. Her pro-terms “that” (i.e., the swelling and pain in P’s legs – Line 48) and “it” (i.e., the prescribed medication that P stopped taking – Line 49) connect her YNI to both her WH-Q and the talk prior to this turn. R4’s YNI enquires about the effects of the medication and the topic agenda of her question is the swelling and pain in P’s legs. The presuppositions inherent in R4’s YNI are that P: (a) was taking the prescribed medication; and (b) stopped taking the prescribed medication. R4’s YNI is designed to prefer a _yes_-type answer.

Answer. P begins answering R4’s WH-Q in overlap with her YNI. P repeats the main part of his answer “more or less” (Lines 50 to 51) after R4 completes her YNI, with the “or less” being in overlap with R4 asking another YNI, “Any changes?” P’s ambiguous utterance “Ah it’s more or less okay ah::: more or less” provides a clausal type-conforming answer to R4’s _how_ question. However, P does not complete his turn and addresses R4’s first YNI (Lines 48 to 49) before she asks the second YNI, “Any changes” (Line 52). P indicates that his turn is not complete in Line 51 because there is no falling or final intonation after the second “less.” Thus, he is in mid-utterance when R4’s second YNI in Line 52 is asked. R4’s YNI “Any changes?” is a follow-up question.
that pursues information regarding possible changes (or lack thereof) in P’s experience of pain. R4’s pursuit for additional information via the YNI in Line 52 indicates that she does not accept P’s answer to her how question as adequate. R4’s movement to another line of questioning in Line 58 indicates that she accepts P’s answer to her YNI question (Line 52) as adequate.

**Exemplar 19: YNI followed by a quasi-ALT-Q; no response to the YNI followed by a type-conforming answer to the ALT-Q.** In this exemplar, R3 asks a YNI followed by a quasi-ALT-Q (i.e., she produces the effect of an ALT-Q without the use of the word “or” between the alternative options). P does not respond to R3’s YNI and produces a type-conforming answer to the quasi-ALT-Q.

Prior to this exemplar, P tells R3 that after his latest round of radiation treatments his experience of physical pain changed. P provides an account that offers several pieces of evidence to support his claim that his pain changed. R3 pursues a description of P’s current experience of pain (Lines 1 to 2). P states that his pain is “present” (Lines 4 to 5; see Exemplar 12 for a detailed analysis). P elaborates on his previous turn by saying that his pain is not worse (Line 11). R3 produces a gist formulation in the form of a partial repeat in reply to P’s assessment: “It’s ((the pain)) not worse (Line 13).

(19) [C8P2: 137-272]

1  R3: Okay. And so INstead of the having the pa:in: pressing on
2     your nerves what's the pain feel like now?,
3     (2.4)
4  P: Now:ah ho-how i-it's like PREsent ah-i-i-
5     [it's present]
6  R3: [It's just the]r:e.
7     (0.4)
8  P: I-ju-it's there ye[ah (               )]
9  R3: [Okay. And is the pain] a-
10    (.)
11  P: >Not not< the::: it's not worse no.
12    (0.3)
13  R3: It's not worse.
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

14   (.).
15   Okay.
16   (0.6)
17  R3:  → And is it an achy pain?,
18   (0.2)
19  → Is it
20   (0.2)
21  something that
22   (0.5)
23  is kind of <always>
24   (0.2)
25  always there?, Does it come and go?,
26   (1.1)
27  P:  → Mine is always there.
28   (0.5)
29  R3:  It’s always there.
30   (.)
31  Okay.=
32  P:  =Always there.

Question. In Line 17, R3’s YNI in her first TCU begins with an “And”-preface that links this question to the preceding talk. This first TCU also is connected to the prior talk via R3’s repeat of P’s use of the pro-term “it” (the pain) and her matching use of the present tense “is” (Line 13). The topic agenda which P’s answer should address is the quality of his pain. R3’s YNI presupposes that P: (a) has pain; (b) wants to report his pain; and (c) is able to articulate his experience of pain. The design of R3’s YNI prefers a yes-type answer.

After a short pause of 0.2 seconds, in which P does not produce a response, R3 switches from enquiring about the quality (Line 17) of P’s pain to the frequency of his pain (Lines 19 to 25). I chose to identify the second and third TCUs in R3’s turn (Lines 19 to 25) as a quasi-ALT-Q instead of two YNIs because she: (a) states two opposing scenarios for when P might experience pain (always versus intermittently); (b) does not pause between the two options to give P an opportunity to answer the first option as a YNI before the second option is delivered (i.e., she delivers the two options as one
continuous turn); and (c) uses prosody in the form of identical intonation contours in the implied alternatives to highlight that she expects P to choose between either “always there” or “come and go.”

R3’s follow-up of a YNI with a quasi-ALT-Q displays her: (a) recognition that P has not conformed to the agenda-setting functions of her YNI; (b) continued effort to understand P’s experience of pain; and (c) recognition that P might be having difficulty articulating his experience of physical pain (which is evidenced by his dysfluency and perturbations in his self-repairs in Lines 4 to 5 when he was asked to describe his pain). R3’s quasi-ALT-Q is connected with the YNI in her first TCU and the previous talk via the partial repeat of the pro-term “it” that references P’s pain (Lines 17 and 25) and the continued matching of the present tense (“is” – Lines 19 and 23; “does” – Line 25). The topic agenda of R3’s quasi-ALT-Q is the frequency with which P feels pain: constantly versus intermittently. R3’s ALT-Q presupposes that P: (a) has pain; and (b) is able and willing to evaluate when he has pain.

*Answer.* The lack of a response from P to R3’s YNI can indicate one of two possibilities. First, it may be that he rejects the action and topic agendas of the YNI and/or that he views at least one of the presuppositions inherent in R3’s question as problematic. It is unlikely that P would reject the first two presuppositions inherent in R3’s YNI because he reported having pain earlier in this consultation and on his ESAS form. It is reasonable to assume that he rejects the third presupposition: he is able to articulate his experience of pain. My presumption is supported via P’s display of difficulty in describing the nature of his pain in Lines 4 to 5. His lack of response to R3’s YNI in Line 17 may be a further display of difficulty. Second, it may be that P’s non-
reply simply indicates that he did not have sufficient time to produce an answer to the YNI before R3 asked the quasi-ALT-Q.

P’s type-conforming answer to the quasi Alt-Q indicates that he: (a) accepts the action and the topic agendas set by the question (i.e., because he repeats one of the answer options provided); and (b) accepts the presuppositions inherent in R3’s question. However, the delay of 1.1 seconds before he answers suggests that he finds something problematic about the question. His answer does not provide an indication of what he may find problematic. It is possible that the format of R3’s quasi-ALT-Q (i.e., the lack of a connecting “or” between the answer options) accounts for the delay. Specifically, R3’s quasi-ALT-Q is on the edge of being recognizable as an ALT-Q; therefore, P needs extra time to consider how best to answer (i.e., with two yes or no answers – one for each YNI component of the quasi-ALT-Q, or with a repeat of one of the provided answer options of the quasi ALT-Q). However, it may be that neither of the two answer options provided completely captures the way in which P would describe the “different” pain he is experiencing: “always there” is an extreme case formulation that does not allow for times when the pain is gone, but “come and go” is not quite strong enough to account for extended periods of time when he experiences the pain.

Another feature of P’s answer that may indicate that he views something about R3’s quasi-ALT-Q as problematic is that his answer provides more information than is required by the action agenda set by the question. That is, P’s choice of the answer options (“always there”) is prefaced with “Mine is.” Currently, there is no literature that examines what a respondent may be doing with an elaborated type-conforming answer to
an ALT-Q. It is possible that P’s answer to R3’s quasi-ALT-Q in Exemplar 19 indicates that there is something problematic about the question in the same way as do full clausal versus phrasal response forms to some WH-Qs (see discussion above, also Fox & Thompson, 2010).

**Exemplar 20: An assertion followed by an ALT-Q; a non-type-conforming response.** In the bolded Q/A-AP in this exemplar (Lines 38 to 42), R1 initially makes an assertion that acts as an observation. Given that R1’s assertion is designed to inform P of how his rankings of his experience of physical pain from the current visit compare to those of the previous visit, a confirmatory answer is not indicated. R1 quickly follows her assertion with an ALT-Q. P provides a non-type-conforming response.

At the beginning of this exemplar, R1 informs P that she will start the consultation by discussing the ESAS he filled in prior to their meeting (Lines 1-5). P acknowledges agreement with this course of action with an affirmative head nod (Line 6). In Lines 8 to 13, R1 informs P that when she compares the ESAS forms that he filled in for his previous visit and this visit, it appears that he is reporting an improvement in some of his symptoms and a worsening in others. R1 explains to P that she is interested in hearing how he is feeling and what symptoms are bothering him currently (Lines 13 to 16). P reports that he is not feeling worse (Line 21) and that there have been no changes

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60 Stivers (2005) and Heritage (2012a) present the ways in which respondents to assertions and questions (not including ALT-Qs) can demonstrate primary rights (i.e., K+ epistemic stance) by providing more than the required answer. Stivers (2005) found that answers to assertions and YNDs that contain modified repeats of the FPP are a way for the respondent to assert primary authority over the topic of the FPP. Given that the type-conforming answer to an ALT-Q is a partial repeat of the question (i.e., one of the answer options provided), the repeat itself would not demonstrate that the respondent is vying for epistemic stance. Note also that in Exemplar 19, P prefaced his repeat with “mine is,” which takes ownership of his experience of pain. This modification of the repeat demonstrates P asserting a strong primary right (i.e., K+ epistemic stance) with regard to his experience of pain. It is possible that P’s expression of ownership of his pain also sets apart his firsthand experience of pain from R3’s generic knowledge of what patients in P’s situation are most likely to experience (i.e., academic knowledge and practical knowledge grounded in experiences with multiple patients).
in his experience of the symptoms since his previous visit (Lines 24 to 26). R1 asks P if his report of no changes since his last visit also applies to his experience of pain (Line 29). P reports that his pain is not worse at the present time (Line 33 and 35).

(20): [C3P2: 60-123]

1  R:  So I just wanted to start out,
2  (.)
3  u::m:
4  (0.5)
5  with the form that you filled out today?,
6  (Nods head up and down slightly)
7  (0.4)
8  P:  I noticed
9  (.)
10 a Couple things had changed from the last time um,
11 (0.3)
12 SOME for the-a >little bit< better? and some a little bit
13 worse. •hhh So:: I just wanted to know how how YOU'RE
14 feeling and
15 (.)
16 and what symptoms are bothering you right now=.
17 P:  =Ah::
18 (0.4)
19 no ↑I've:
20 (.)
21 I'm not feeling worse?,
22 R:  =((Nods head up and down))
23 (1.2)
24 P:  =I would say ah:
25 (1.0)
26 n:-no changes since the last time=.
27 R:  =O;kay.
28 (0.2)
29 •hhh In terms of the pain?, there's no change.
30 (.)
31 P:  =right now.
32 (.)
33 R:  Very good. •hh
34 R1:  → In FACT You ranked it as:: a >little even bit better
35 than the last time ar-around, >do you think that that's
36 the truth?,< or somewhere $(hh)huh probably about the
37 same$.
38 P:  → =It could be yeah::.
39 R:  Okay. ↑O;kay. •hh Ah ↑what are you using< ↑for the pain
40 right now.
41 (0.6)
Multi-unit questioning turn. R1’s first TCU “In fact you ranked it as a little even bit better than the last time around” (Lines 38 to 39) is a gist formulation that points out the difference between P’s self-reported pain scores on the previous and the current ESAS forms he completed. This assertion presupposes that P does not remember his previous ranking. As well, it sets up the aspects of pain to be enquired about in R1’s ALT-Q as severity and time. R1’s gist formulation is linked to information given previously via the pro-term “it” that refers to P’s evaluation of his level of pain. R1 completes her turn with an ALT-Q (“do you think that that’s the truth or somewhere (h)huh probably about the same”). R1’s pro-term “that” (in “that’s”), which refers to the most recent ranking, links her ALT-Q with the first TCU (i.e., assertion) of her turn. The topic agenda of R1’s ALT-Q is the accuracy of P’s previous pain reports. R1’s question presupposes that P: (a) previously evaluated his experience of pain; (b) is able and willing to compare his previous ESAS ranking of pain with his current ranking; and (c) is able and willing to evaluate the accuracy of his reports.

Response. P’s response is not type-conforming because he does not repeat one of the answer options provided in R1’s ALT-Q; rather, he provides the ambiguous response “It could be yeah.” P’s response is non-specific with regard to the aspects of pain and it rejects the action agenda. It indicates that he finds something problematic about R1’s question. It may be that P finds the alternatives provided to be problematic: “do you think that that’s the truth?” challenges the accuracy of P’s most recent report of pain on the ESAS and “somewhere probably about the same” offers a correction to his report. The
problem may also be with the presuppositions, namely that P is able and willing to compare his rankings and to evaluate their accuracy.\(^{61}\)

*Exemplar 21: An assertion followed by a YND; a type-conforming, dispreferred answer.* In the bolded Q/A-AP in Exemplar 21, R2 offers a gist formulation that summarizes P’s previous talk. R2 follows her assertion with a YND. P provides a dispreferred, type-conforming answer.

This exemplar begins with R2’s *how* question, which inquires about P’s experience of physical pain subsequent to his most recent chemotherapy session (Lines 1 to 3). P initially states that his pain has not changed. He follows this statement with an assertion that he usually has more pain, particularly in his pelvis, with new chemotherapy sessions. R2 acknowledges receipt of this information with “Yes” in Line 16. In Line 20, P expresses uncertainty whether his lack of physical pain during the chemotherapy sessions indicates a positive or negative outcome. He follows this with a candidate suggestion (denoted by his downgrading tag phrase “I think” in Line 26) that the only way to determine if the lack of pain has positive or negative implications for the progression of his illness is for him to have a CT scan. R2 confirms P’s assumption (Line 28).

*(21): [C6P2: 99-200]*

1. R2: How is your:::
2. (.)

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\(^{61}\) The ambiguity of P’s answer may also reflect his judgment that it is inappropriate for R1 to offer a candidate correction for his evaluation of his own experience. The sequence is similar to that described by Koshik (2005) in which instructors first identify a problem in a student’s text (in this case, not done by repetition, but by challenging the truth), and then offer a candidate correction. If Koshik’s (2005) analysis applies in the present case, then the second answer option would be the preferred answer (with which P’s answer does not align). The ambiguity in P’s answer may also convey that it is presumptuous of R to presume (in her opening assertion) that P does not remember his previous rankings (even though this may be the case).
P: "It hasn't changed ah::
(0.7)
With this new chemo I: I usually ah
(0.2)
I::--I have more pain::,
(0.4)
R2: [ O:kay ].
P: [>especially<] in my pelvis.
(0.4)
R2: Yes.
(0.7)
P: I have so,
(0.9)
I dunno if this for better or for worse.
(0.7)
"But ah"
(0.3)
the only way is to check
(0.2)
by a CT scan I think.
(0.4)
R2: "Right".
(0.4)
→ hh >And so< your perception is that
(0.4)
the pain has been COStant. It hasn't
(0.4)
deCReased or it hasn't increased
(0.2)
in with this last session?=
P: → =Yeah yeah it< increased when: they began
[the new] chemo?,
R: [ Right ]
(0.5)
P: and there it is:::
(1.1)
or else
(0.6)
the same lef,
(0.6)
R: So it had gone ↑up
(0.3)
abt
(0.2)
the start of the sessions.=
P: =Y:eah.
(1.1)
R: Okkay.
(0.6)
P: I'm usually I have pain when I am sittin.
(0.4)
R: Yep.
Multi-unit questioning turn. In Line 30, R2’s “And”-preface and “so” link the gist formulation in her multi-unit turn at talk to P’s previous talk. The remainder of R2’s assertion is framed with the evidential (Chafe & Nichols, 1986 as cited in Heritage & Clayman, 2010, p. 160; Peräkylä, 1998) “your perception is” which verbally retrieves the topic context in P’s earlier turn. Given that R2 completes her assertion TCU with final falling intonation, a clear indication has not been given to P that a confirmatory answer is expected (Line 32). R2 promptly follows this TCU with a YND that unpacks what she meant by “constant” in her assertion: “It hasn’t decreased or it hasn’t increased in with this last session?” (Lines 32 to 36). The rising intonation at the end of R2’s YND makes relevant a confirmatory answer from P. R2’s turn enquires about the severity and effects of treatment aspects of pain. The topic agenda of R2’s YND is the stability of P’s experience of pain during his chemotherapy treatments. The negative declarative “hasn’t” prefers a no-type answer. The presuppositions inherent in R2’s YND are that P: (a) has pain; and (b) had chemotherapy.

Answer. P’s answer conforms to the action agenda of R2’s question with a type-conforming “yeah” answer. P’s answer accepts the topic agenda and the presuppositions. However, “yeah” is the dispreferred answer. P’s follows his dispreferred answer with an account that is in line with the aspects of pain enquired about in R2’s question (i.e., his pain increased rather than decreased [severity], at the beginning of the new chemotherapy [effects of treatment]). An interesting feature of P’s dispreferred answer is that it does not display all of the usual qualities of a dispreferred answer, that is, his answer is not delayed and/or deferred. Rather, the delivery of his answer (i.e., latched to the end of R2’s turn) is more representative of a preferred answer. Given that P just informed R2
that his pain increased in his pelvis at the start of the chemo session, and that R2’s multi-unit questioning turn was a gist formulation assertion followed by a gist formulation YND, P’s quick answer displays that he was likely waiting to correct R2’s misinterpretation of his earlier talk once her turn was complete.

Further Analyses

Structural Analysis of Physicians’ Multi-Unit Questioning Turns

According to Sacks et al. (1974), many multi-unit questioning turns at talk display a recurrent pattern that consists of three parts that occur in the following order: the first part “addresses the relation of a turn to a prior” turn; the second part is specific to the current turn; and the third part “addresses the relation of the turn to a succeeding” turn (p. 722). This three-part organizational structure latches the speaker’s turn to the turns on either side of his/her turn. For example, a physician may say to a patient “You say you have pain in your arm. Your arm looks swollen. Can you lift it?” The first TCU connects the physician’s multi-unit questioning turn at talk with the patient’s prior talk. The second TCU is specific to the physician’s turn and the third TCU makes relevant an answer from the patient in the next turn. However, occasionally speakers of multi-unit questioning turns at talk do not adhere to the three-part pattern. In these cases, it is the second part specific to the current turn that is omitted. According to Sacks et al. (1974), the turn-taking system “exerts pressure” (Sacks et al., 1974, p. 723) on the speaker to accomplish the turn parts at the first possible completion (i.e., in a single TCU or in as few TCUs as possible). TCUs in a multi-unit questioning turn at talk should be understood in reference to the jobs that they are doing (e.g., seeking information); therefore, the number of parts and the function of the parts are dependent on the immediate interactional context.
In the present data, none of the seven physicians’ multi-unit questioning turns at talk demonstrate the three-part pattern identified by Sacks et al. (1974). Rather, all seven demonstrate only two parts: the first and third parts\(^{62}\). For five of the multi-unit questioning turns, the pattern is consistent:

1) the first component of the multi-unit questioning turn summarizes either some information that was provided by P via his completed ESAS form or an elaborated telling in his prior turn or prior turns; and

2) the second component of the multi-unit questioning turn either seeks confirmation regarding the accuracy of a gist formulation/summarization or it requests clarification of some information that was provided by P in a prior turn.

For the other two multi-unit questioning turns (Excerpts #51 and #46), the first component connects the turn to previous talk via an *and*-preface, but this part is not a summary, rather, it is a question. This first questioning component is followed by a second question with minimal pause between them (see Exemplars 18 and 19). Table 4 shows the structural analysis of the physicians’ multi-unit questioning turns.

\(^{62}\) In the present data, a part of a turn is not always equivalent to one TCU. For example, the first part of the physician’s multi-unit questioning turn in Excerpt #54 has two TCUs, “When we look at you’re your um symptom assessment report um your pain is constant. ((first TCU)) It was two the last time, it’s two this time ((second TCU)).”
<table>
<thead>
<tr>
<th>EXCERPT SEQUENCE</th>
<th>FIRST COMPONENT</th>
<th>ANALYSIS</th>
<th>SECOND COMPONENT</th>
<th>ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>49/15</td>
<td>And from one to ten when ten is the worst pain so you (.) you describe that you were (0.4) having a tree.</td>
<td>Gist formulation of information provided by P on his ESAS prior to the consultation. “And”-preface links this turn to prior talk.</td>
<td>Is that [correct]?</td>
<td>Seeks confirmation (via a YNI) either that P described his pain as a three or that his level of pain is a three.</td>
</tr>
<tr>
<td>50/16</td>
<td>So:: it seems that the- the- the day (0.3) the- the pain during the da::y has been stable.</td>
<td>Summary of P’s elaborated telling in his prior turn. “So”-preface links this turn to prior talk.</td>
<td>Is that [correct]?</td>
<td>Seeks confirmation (via a YNI) for the accuracy of her summary.</td>
</tr>
<tr>
<td>51/18</td>
<td>And</td>
<td>The words “And and “now” are used as affiliators to a prior turn in which P provided an elaborated telling about his previous pain.</td>
<td>how is the pain now:. Is:: ah:: is:: that [bothersome::e &gt;after you stop it]&lt;</td>
<td>Seeks clarification regarding P’s current experience of pain.</td>
</tr>
<tr>
<td>46/9</td>
<td>And</td>
<td>The words “And” and “it” (P’s pain) are used as affiliators to prior turns in which P describes the pain in his legs as “present.”</td>
<td>is it an achy pain? (0.2) Is it (0.2) something that (0.5) is kind of always (0.2) always there?, Does it come and go::?:</td>
<td>Seeks clarification regarding P’s description of his experience of pain</td>
</tr>
<tr>
<td>52/1</td>
<td>In FACT You ranked it as:: a little even bit better than the last time ar-ar-around,</td>
<td>This TCU is a gist formulation and “You ranked” is used an affiliator to the information provided by P on his ESAS prior to the consultation. The pro-term “it” (P’s pain) is used as an affiliator to a prior turn in which P describes his pain.</td>
<td>&gt;do you think that that’s the truth?, &lt; or somewhere (hh)huh probably about the same.</td>
<td>Seeks clarification regarding P’s apparent inconsistent reports of pain on his ESAS forms and what he said during his consultation.</td>
</tr>
<tr>
<td>53/4</td>
<td>&gt;And so&lt; your perception is that (0.4) the pain has been CONstant.</td>
<td>Summary of P’s elaborated telling in his prior turn. “And so”-preface link this turn to prior talk.</td>
<td>It hasn’t (0.4) decreased or it hasn’t increased (0.2) in with this last session?</td>
<td>The rising intonation at the end of the YND makes relevant a confirmatory answer from P. Seeks confirmation that her summary is correct.</td>
</tr>
<tr>
<td>54/5</td>
<td>When we look at your (0.3) your u:m: pt symptom assessment (. ) report (0.5) u:m (. ) your pain is constant. It was (0.2) two the last time, it’s two this time. (0.2).hhh U::m: (1.0) but you (.) seemed &gt;to have&lt;(0.3) &lt;been: more&gt; aggressively showing (0.6) ah::: just the symptoms were (.) a-or may be more so there the last time.</td>
<td>This turn contains a gist formulation; “When we look at your symptom assessment report” is used as an affiliator to the information provided by P on his ESAS prior to the consultation. The gist formulation is followed by a specification (“It was two the last time, it’s two this time”) and an observation (“Um but you seemed to have been more:::”)</td>
<td>&gt;That could&lt;_ just be:::. (.) how you were drawing but, (0.5)</td>
<td>The 0.5 second pause makes relevant a answer from P. Seeks clarification from P about the information he provided on his ESAS.</td>
</tr>
</tbody>
</table>
The exact function of the physicians’ use of multi-unit questioning turns as another method of assessing P’s physical pain (in conjunction with the use of single-unit questioning turns) is unclear from the analysis of the limited sample in the present study. However, I speculate that the types of multi-unit questioning turns in the present data are another component of the routine checklist during the history-taking phase of palliative care consultations. There are several pieces of evidence that support my speculation. First, all of the multi-unit questioning turns occur in the first part of the consultation (i.e., between the medical resident and the patient), which is designated as the part of the consultation in which the residents are to gather as much information about P’s situation as possible (i.e., the history-taking phase of the consultation). Second, all of the residents have included some element in their first TCU (e.g., and- and so-prefaces) that connects the remainder of their turn to some piece of information provided by P. Third, with two exceptions (Excerpts #51 and #46), the residents use the second part of their multi-unit questioning turns to ensure that they have accurately interpreted the pain information P provided (that is, a question seeking confirmation or clarification that follows the summary or gist formulation). The two exceptions in this data are double question multi-unit questioning turns, which prove to be problematic. That is, P answers only one of the questions (Excerpt #51 receives an answer only to the first question; Excerpt #46 receives an answer only to the second question). Finally, P demonstrates that he is orienting to the routine-checklist objective (see Stivers & Heritage, 2001) because his answers are usually

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63 According to Stivers and Heritage (2001), it is a common practice for primary care physicians to use restrictive, routine checklist-type questions at the history-taking phase of the consultation as a means of quickly collecting specifics about the patient’s situation. In particular, physicians ask a series of questions that only require yes or no answers (or an equivalent token) or specific answers (e.g., naming a body part). The routine checklist activity usually involves the physician asking the first question as a fully formed YNI or YND, with each successive question becoming more truncated in a process of ellipsis (see Chapter 1 for details of this research).
type-conforming and he does not respond with a narrative about some unrelated or loosely related topic. In the instances in which P’s answer is not type-conforming or is expanded, the additional information serves the purpose of (a) adding a piece of relevant information (e.g., Excerpt #50 – P adds that his pain is stable during the night as well as the day); (b) indicating something problematic about the design of the question (e.g., Excerpt #52 in which one of the alternatives challenges the patient’s veracity); or (c) correcting a piece of information included in the residents’ turn (e.g., Excerpt #53 – P corrects R2’s gist formulation – see Exemplar 21).

**Summary of Single and Multi-Unit Questioning Turns**

I analyzed a total of 44 questions in the single-unit turns. The distribution of the questions was as follows: 17 YNIs (38.6%), 15 YNDs (34.1%), 9 WH-Q (20.5%) and 3 ALT-Q (6.8%). There were seven multi-unit questioning turns. The type of questions in the multi-unit questioning turns was: YNI (4), YND (2), ALT-Q (2) and WH-Q (1). The physician’s questions were analyzed using the four dimensions of question design (Boyd & Heritage, 2006; Heritage, 2010).

**Agenda**

**Action agenda.** The majority of the time the patient conformed to the action agenda of the type of question asked (i.e., gave a type-conforming answer). Specifically, the patient provided a *yes*- or *no*-type answer to 24 of the 38 polar questions (i.e., YNIs and YNDs): 20 of the 32 in the single-unit turns; 4 of the 6 in the multi-unit turns). When the patient rejected the action agenda, it was by: (a) providing an agenda-transforming

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64 This summary is based on the analyses of the full data set presented in Table 2: Single-Unit Questioning Turns and Responses and Table 3: Multi-Unit Questioning Turns and Responses, i.e., it is not based solely on the analyses of the exemplars.

65 See Table 2.
answer (see Stivers & Hayashi, 2010) (Excerpts #1 and #16 – see Exemplar 9); (b) providing a response but not an answer to the question (Excerpts #25 and #5 – see Exemplar 10); (c) repeating part of the physician’s question as an answer (Excerpts #14, #34, #30 and #26); (d) providing an account for a dispreferred answer (Excerpts #23, #7 – see Exemplar 8, and #28 – see Exemplar 6); (e) providing a non-committal answer (Excerpt #35); and (f) not providing a response to the question (Excerpts #51 – see Exemplar 18, and #46 – see Exemplar 19; these responses occurred in multi-unit turns with double questions).

In the WH-Qs, the patient provided a type-conforming answer 7 of 10 times (6 of the 9 in the single-unit turns; the one in the multi-unit turns). When the patient rejected the action agenda he did so by: (a) providing a non-committal answer (Excerpts #39 and #37 – see Exemplar 14); and (b) repeating the WH-Q part of the physician’s question as a means of seeking clarification of the type of question being asked (Excerpt #42a). In the ALT-Qs, the patient repeated one of the answer options provided in the physicians’ question (i.e., a type-conforming answer) 3 of the 5 times (2 of the three in the single-unit turns; 1 of the 2 in the multi-unit turns). The patient rejected the action agenda of the physicians’ questions twice by providing an answer that did not contain one of the answer options (Excerpts #45 – see Exemplar 16, and #52 – see Exemplar 20). In both cases, the patient’s answer and the surrounding talk indicated that he viewed both alternatives as inappropriate.

In each instance in which the patient rejected the action agenda (i.e., provided a non-type-conforming answer), his answer/response or lack thereof indicated that he viewed something about the physicians’ questions as problematic. What the patient
viewed as problematic was the action agenda and/or some other component of the questions. This is discussed further in the summaries of the other dimensions of question design.

**Topic agenda.** In most cases, the topic of the physicians’ questions presumed that the patient had physical pain (44 of the 53 questions). Nine of the physicians’ questions were no-pain questions ⁶⁶ (e.g., “No chest pains or palpitations” Excerpt #22b; “Any pains?” Excerpt #18 – see Exemplar 4). In the questions that presumed the patient had pain, the topic of the questions often involved some aspect of pain. For example, the topic of the physician’s question in Excerpt #33 (see Exemplar 2) related to the management/control aspect of pain, the topic of the question in Excerpt #2 (see Exemplar 5) related to the effects of treatment aspect, and the topic of the question in Excerpt #7 (see Exemplar 8) related to consequences of pain aspect.

In most cases, the patient’s answers conformed to the topic agenda. The patient rejected the topic agenda when he: (a) responded but did not answer the question (Excerpts #25, #39, #42a, #5 – see Exemplar 10, and #37 – see Exemplar 14); (b) provided a transformative answer (Excerpts #1 and #16 – see Exemplar 9); and (c) did not respond (Excerpt #51 – see Exemplar 18 and #46 – see Exemplar 19). The patient’s rejection of the topic agenda indicated that he viewed something problematic about the topic. For example, in Excerpts #5, #25 and #16 the topic of the physicians’ questions was the management/control of the patient’s pain (more specifically, in #5 and #16 the patient’s satisfaction with the management/control of his pain). It is possible that the patient was not willing to discuss this topic as it might involve him giving a less than favourable evaluation of the pain management care he received from the physicians.

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⁶⁶ An explanation of questions designed for a no-pain answer is provided in Chapter 4.
Presuppositions

The physicians’ questions usually had at least two presuppositions and as many as four. The most common was that the patient had pain. Other presuppositions were that the patient was able and willing to describe his pain, was willing to report his pain, was taking medication to control his pain, had at least some control over his pain, might be willing to take more medication, might be willing to change how his pain was being controlled, and was willing to evaluate his satisfaction with the pain management plan developed by the physicians.

The patient’s immediate, type-conforming answers confirmed the inherent presuppositions in the physicians’ questions. However, on several occasions the patient’s answers contained elements that indicated that he possibly viewed something problematic about one or more of the presuppositions in the physicians’ questions. For example, in the instances in which the patient’s type-conforming answer was deferred and/or contained some type of qualification (e.g., Excerpt #2: R “So when you take the medication do you have relief?”, P “Hm: (0.4) Yeah. (0.5) It’s (0.9) Yeah (0.4) I have relief”) the patient displayed that he did not accept the presuppositions unconditionally (see Exemplar 5). Also, the patient’s non-committal answers (e.g., Excerpt #33 – see Exemplar #2) allowed for possible hearings that might be different than what was presupposed by the question. Further, the patient’s answers that involved replacement transformations or partial-modified repeats demonstrated his resistance to the design of the questions and worked to reject at least some of the inherent presuppositions.
Preference

As previously noted in Chapter 2, there are two types of preference: (a) preference for a type-conforming answer over a non-type-conforming answer; and (b) preference for a particular answer to a polar question (YNI or YND) that is influenced by grammatical design and polarity of the question. As stated in the summary of the action agenda, the patient provided a type-conforming answer to the majority of the physicians’ questions. With regard to the preference for a particular answer, the physicians’ YNIs and YNDs were negatively polarized (i.e., preferred a no-type answer because of the inclusion of a negative polarity item such as any, ever, not, or no) 15 times (out of 32). The negative polarity items were used most frequently in YNIs (11 of 15). The patient answered with the preferred answer (i.e., aligned with the preference structure of the question) to 12 of the 15 negatively polarized questions. Of special note was Excerpt #28 (see Exemplar 6) in which the patient initially answered with a non-type-conforming, preferred answer (“Not painful”), but during his elaborated answer changed his answer to dispreferred (“maybe a bit more painful”). Also, in Excerpt #1, the patient gives a transformative answer that does not align with the preferred answer format of the question. His transformative answer reports a slight change in his experience of physical pain (“it hasn’t changed a lot”), instead of aligning with the preference structure of the question that would have had him affirm that he had nothing to report about his pain.

The physicians’ YNIs and YNDs were positively polarized (i.e., preferred a yes-type answer) 17 times (out of 32); 11 of the 17 questions were YNDs. The patient answered with the preferred answer to 12 of the 17 positively polarized questions. Of special note were Excerpts #5 (see Exemplar 10) and #25 in which the patient responded
to but did not answer the questions (#5 “Uh”; #25 “Um”). Interestingly, both of these questions related to the patient providing an evaluation of the current pain management plan. Further, the patient gave a transformative answer in Excerpt #16 (see Exemplar 9), which is another question requiring him to evaluate the pain management plan. In this case, the patient pre-empted a physician’s next question that might have offered him more medication with the explicit rejection “I don’t want to take more.”

**Epistemic Stance**

By virtue of asking a question that seeks information, the physicians positioned themselves in a relatively unknowing (K-) epistemic stance in relation to a projected knowing (K+) stance of the patient for the topic being discussed (see Heritage, 2010; Heritage & Clayman, 2010). The K- epistemic stance of the physicians varied slightly depending on the type of question (i.e., YNI, YND, ALT-Q or WH-Q) they asked. This pattern was consistently displayed in the physicians’ questions in the present data. In providing the physician with a relevant answer, the patient demonstrated a K+ epistemic stance. The K+ epistemic stance of the patient varied depending on the type of answer he provided.

Although epistemic stance was analyzed for all of the excerpts in the dataset, the exemplar analyses did not address epistemic stance unless there were variations from the basic pattern. An example of a deviation from the basic pattern was discussed in Exemplar 6 in which the physicians self-initiated, self-repair, which changed her question from a YNI format to a YND, allowed her to appear more knowledgeable (i.e., be in a less K- epistemic stance) about the patient’s experience of pain. The patient’s turn-initial repetition of “Not painful” claimed greater K+ epistemic stance and social entitlement.

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67 See Chapter 1 for a full explanation of epistemic stance.
over the relevant information about his experience of pain than the YND question afforded (see Heritage & Raymond, in press). Excerpt #24 provides another example of a turn-initial repeat in the patient’s answer. In this case, the patient performed a self-initiated, self-repair that rejected the physician’s use of the minimizer “just” that downgraded his experience of pain. The patient claimed greater K+ epistemic stance regarding his experience of pain and he disaligned with the physician’s word choice that diminished the importance of this experience of pain.

**Principle of Optimization**

The principle of optimization was displayed when the physicians’ polar questions were designed so that the preferred answer confirmed an optimal health outcome. For sixteen of the 24 optimized questions, the optimal health outcome was that the patient’s pain was stable (i.e., made relevant answers that indicated no change in pain such as Excerpt #20 “In terms of the pain? there’s no change”; no new pain such as Excerpt #19 “Any new pains in the back here?”; or that the patient’s pain was managed such as “So it sounds like it it’s the pain is well controlled”). Such an outcome is consistent with the information given to the residents about the best case scenario in this palliative context. The patient accepted the optimized design in ten of these questions. For the eight optimized questions that are not consistent with the mandate (7 of which are no-pain questions), the patient clearly rejects the optimized design for 2 questions; he accepts the design for six but displays (e.g., through delay, qualification) that there is some problem with these questions. When the patient displayed his resistance to the optimized questions, he did so via several devices: replacement transformation, the use of hedged and non-committal answers, and dispreferred answers that corrected an inherent
presupposition in the question and that resisted the limits imposed by question designs (e.g., YNDs, negatively polarized questions) in order to report something regarding his pain.

**Principle of Problem Attentiveness**

The principle of problem attentiveness is displayed when a physician designs questions that are broadly in line with a symptom previously mentioned by a patient and that presupposes there is a problem (see Stivers, 2007). A total of 24 of the 53 physicians’ questions were designed to be problem attentive. Fourteen of the 38 physicians’ polar questions displayed the principle of problem attentiveness (e.g., Excerpt #32 “It’s always you always feel it there”; Excerpt #30 “Okay it’s both legs?”; Excerpt #13 “Is that a new pain?”). The patient provided the preferred answer to 12 of the 14 problem attentive polar questions. He provided a dispreferred answer to two questions: once to clarify that the pain he described was not a new pain and once to pre-empt an offer of more medication by explicitly stating that he did not want to take more medication. He did not respond to two of the problem attentive polar questions. Seven WH-Qs (e.g., Excerpt #41 “And so instead of having the pain pressing on your nerves what’s the pain feel like now?”; Excerpt #39 “Tell me how your pain’s different”) and three ALT-Qs (e.g., Excerpt #47 “And when you say unusual is it is more painful or is feel different?”) were designed to be problem attentive.

**Progressivity and Cohesiveness**

In the present data set, several devices in physicians’ turns facilitated the progressivity of the talk and aided in constructing a sense of cohesiveness in the consultations. Specifically, the physicians’ questions began with an *and*-preface seven
times and an *and so*-preface twice. These linked new questions to preceding question/answer adjacency pairs (Q/A-APs). The physicians’ questions began with a *so*-preface seven times and an *I mean*-preface once. These conveyed a resumption of a temporarily interrupted line of telling (see Bolden, 2006). Also, the use of routine checklist questioning expedited the progressivity of the talk and created cohesiveness in the medical questioning segments (see Stivers & Heritage, 2001). The patient’s type-conforming, preferred answers to the routine checklist questions demonstrated that he oriented to the routine checklist objective, which contributed to the progressivity and cohesiveness of the talk.

Other devices in the physicians’ questions that aided the progressivity and cohesiveness of the talk were gist formulations\(^{68}\), upshot formulations\(^{69}\), evidentials (e.g., *it sounds like*), pro-terms (e.g., “it”) that reference the patient’s prior talk, and partial modified repeats of components of the patient’s prior turns in their questions. Also, in Exemplar 1, the elongation of sounds in words displayed the physicians’ continued occupancy of the turn spaces. These features made the patient’s non-responses at the TRPs less noticeable and prevented disruption in the progressivity of the talk. Finally, in Exemplar 2 the physician performed a self-initiated, self-repair that caused a brief interruption in the progressivity of the talk by clarifying to what her use of the pro-term “it” referred; she then proceeded with her talk. The repair grounded her talk in the earlier suspended talk and prevented a future interruption in the progressivity of the talk that may have occurred if the patient had requested clarification of the pro-term in his next

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\(^{68}\) A gist formulation is a current speaker’s summary of another speaker’s previous discourse (Heritage & Watson, 1979).

\(^{69}\) An upshot formulation is one speaker’s formulation of what another speaker said via drawing out the relevant implications of the other speaker’s talk (Antaki et al., 2005).
turn rather than answering the question. On one occasion (see Exemplar 8), the patient’s answer connected his turn to prior talk even though the physician’s new topic question did not lexically connect her question to prior talk with a device such as a so- or and-preface.

**Deictics and Physical Gesticulations**

Heath (1989) found that while replying to history-taking questions, patients commonly used deictics (e.g., here, there) and physical gesticulations (e.g., pointing, rubbing areas of the body) to indicate the site of their physical pain and to describe and present their suffering. In the present study, both the physicians and the patient used deictics and physical gesticulations\(^{70}\) to refer to the patient’s physical pain. For example, during the physicians’ physical examination of the patient, the physicians would use deictics in questions such as “In here?” (Excerpt #9) while they were palpating or examining an area of the patient’s body. Due to ethical considerations that exempted the physical examinations from recording, it was not possible to see where the physicians were touching or pointing during the examinations when they asked the patient questions that included a deictic. Sometimes it was possible to determine the location because the physicians informed the patient where they were going to touch prior to asking the questions about pain in a specific area. During history-taking the physicians would ask questions such as “You always feel it there?” (Excerpt # 32). This type of use of a deictic did not accompany pointing or touching from the physician; rather, the physician’s use of “there” referred to a particular site the patient had indicated in his talk in the just prior turn.

\(^{70}\) In the present data set not all of the consultations were video-taped and in some cases the video-camera was not positioned to capture all of the physical gestures. Consequently, an analysis of the physical gestures could not be conducted in some cases.
The patient used deictics when giving such answers as “It’s like ah pelvis ah more here from the right side” (Excerpt # 48) and “As in feel different not normal feelin because here for example is everysing normal as it was before the cancer” (Excerpt 47 – see Exemplar 15). When the patient used a deictic he also pointed or rubbed the area he was referring to in his answer. In some instances, the patient also used physical gesticulations when giving answers that did not involve a deictic. For example, in Excerpt #43, the patient reported that he had a “usual feelin from the outer side of my legs” while simultaneously he rubbed his hands up and down the outer side of his legs. Overall, deictic and physical gesticulations by the physicians and the patient were used sparingly during the talk regarding the patient’s physical pain.

Given that the quality and amount of information physicians obtain during consultations is closely related to their ability to question patients (Heritage, 2010; Lussier & Richard, 2004) in a manner that encourages elaboration (Heritage, 2010), the next section will focus on patterns of elaboration in the question and answer adjacency pairs (Q/A-APs).

Patterns of Elaboration in Q/A-APs

In this section I (a) present some patterns of elaboration that have been identified in the CA literature for each of the four types of questions (YNIs, YNDs, WH-Qs and ALT-Qs); (b) discuss the ways in which the findings from the analyses of the question/answer adjacency pairs (Q/A-APs) in the present study conform to or deviate from these patterns; and (c) account for the deviations from the patterns. I first consider

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71 Type-conformity of the answers to the design of the questions will not be discussed as this is not relevant to elaboration. Non-type-conformity of the answers in the deviant cases will only be discussed if the non-type-conformity is relevant to elaboration. That is, if the non-type-conformity of the answer
the individual question types for questions appearing in the single-unit (SU) turns and in
the multi-unit (MU) turns that contain only one question\textsuperscript{72}. I then discuss the two turns
that contain two questions\textsuperscript{73}.

**Yes/No Interrogatives**

CA researchers (e.g., Heritage, 2010; Raymond, 2010) have identified several
consistent patterns in YNI Q/A-APs.

**Pattern 1.** A non-optimized YNI designed to prefer a yes-type answer (i.e.,
positively polarized) will receive some elaboration in the answer when the respondent
gives either a preferred answer (e.g., Heritage, 2010; Raymond, 2010) or a dispreferred
answer (Heritage, 1984). In the present study, no YNI Q/A-APs display conformity to the
pattern when the preferred answer is given; rather, three YNI Q/A-APs deviate from this
pattern (i.e., elaboration is not provided). Two YNI Q/A-APs display conformity to the
pattern when the dispreferred answer is given and there are no deviations. In these cases,
the elaboration acts as an account that provides an explanation for why the preferred
answer is not being offered

**Pattern deviation with preferred answer.**

**Q/A-AP 1** (see Exemplar 17):
1 R: And from one to ten when ten is the worst pain so you (. ) you describe that you
2 were (0.4) having a tree. (0.2) Is that [correct]?
3 P: [ Yeah ] yeah.

The first TCU of R’s multi-unit turn in Q/A-AP 1 is an assertion in which R reads
the severity of pain question on the ESAS form and P’s most recent answer. R’s

\textsuperscript{72} 19 YNIs (17 SU; 2 MU); 17 YNDs (15 SU; 2 MU); 9 WH-Qs (9 SU); and 4 ALT-Qs (3 SU; 1 MU).

\textsuperscript{73} 2 YNIs, 1 WH-Q and 1 ALT-Q.
subsequent YNI (i.e., the second TCU) asks P for an affirmation\(^74\) that she read his ESAS answer correctly. Given that R’s first TCU is a repeat of P’s answer on the ESAS form, her question “Is that correct?” (when considered in sequential context) does not make relevant elaboration. It can be argued that given the design of R’s multi-unit turn, the YNI acts like a YND, therefore seeking confirmation\(^75\) rather than affirmation and discouraging elaboration. P’s non-elaborated answer treats R’s YNI as a YND.

**Q/A-AP 2:**

1. R: U::m:: (0.2) do you feel it occasionally you said.
2. (.)
3. P: Occasionally.

R’s YNI in Q/A-AP 2 asks P for an affirmation of previously reported information (i.e., just prior to Q/A-AP 2 P reported that he “sometimes” feels pain in his pelvis). R’s indirect reported speech (see Wood & Kroger, 2000) “you feel it occasionally you said” paraphrases P’s previous talk (i.e., “it” is substituted for the pain in his pelvis; “occasionally” is substituted for “sometimes”). Given that R marks that she is paraphrasing P’s talk (via “you said”) her YNI acts like a YND (similar to the YNI in Q/A-AP 1) in that it makes relevant a confirmation versus affirmation of the paraphrased information and discourages elaboration. P provides a preferred answer (i.e., he confirms R’s indirect reported speech that he feels the pain “occasionally”).

**Q/A-AP 3\(^{76}\):**

1. SP: •hhh
2. (0.2)
3. ARE You happy with where your pain control is now.
4. (1.3)
5. P: U::h:
6. (0.7)
7. SP: Or could it be better?

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\(^{74}\) An answer to a YNI.

\(^{75}\) An answer to a YND.

\(^{76}\) The Q/A-AP being examined is bolded in the sequence of talk.
Prior to the bolded Q/A-AP, SP asks P via an optimized YNI to evaluate the current pain control strategy (Line 3). A lengthy pause of 1.3 seconds ensues, followed by a response but not an answer (“Uh”) and another lengthy pause (0.7 seconds). SP subsequently treats P’s response as signaling that something is accountably wrong with her question. She then adds a candidate alternative of “Or could it be better?” via a turn increment in Line 7, which constructs a pseudo-ALT-Q (via the use of “Or”) that offers P a choice between the optimized option in Line 3 and the non-optimized option in Line 7. SP’s YNI in Line 7 prefers an answer that states that the current pain management strategy for P (referred to by the pro-term “it”) needs to be improved; a preferred answer would suggest that an increase in pain medication is required and imply that P’s physical pain may be changing for the worse. As well, SP’s question implicitly asks P to evaluate the current pain management strategy (and by association the care he is receiving from the physicians). P defers his “yeah” answer with the downgraded hedge (“I think very”) before he finishes his turn with “it’s okay.” It is unclear whether the pro-term “it” (in “it’s” – Line 9) refers to the pain management care he is receiving from the physicians or his experience of pain. In either case, “it’s okay” contradicts the preferred answer of “Yeah” he initially provided. However, the implication of the contradiction, or what it does, is different depending on the referent for “it.” That is, if “it” refers to the improvement of the pain management plan, “okay” implies that his current pain management is sufficient. The contradiction prevents P from having to criticize the pain management care and from having to account for why the management of his pain needs to be improved. If “it” refers to his experience of pain, “okay” implies that his pain has
not become worse; therefore, he does not require a change to his pain medication and he would not need to elaborate on how his pain has changed for the worse.

In summary, the three deviations with a preferred answer from Pattern 1 can be understood in terms of problems with the design and content of the YNI questions that suggest a basis for the deviations from the usual pattern. First, if a YNI is either part of a multi-unit questioning turn that contains a component that repeats previously reported information (e.g., via a reading of a report), it acts like a YND requiring confirmation versus affirmation and discourages elaboration. In instances such as these, where the YNI asks about correctness, elaboration in the answer is not required because elaboration has already been provided in the assertion prior to the YNI (referred to by the pro-term “that” in the YNI). Second, if the YNI explicitly asks for an evaluation that is potentially depreciatory (e.g., about someone’s efforts) or that would indicate a negative progression (e.g., of diseases), a recipient may choose to answer in as brief a manner as possible to avoid addressing the negative connotations in the question. In general, the patient’s lack of elaboration in his answers marks a problem with the design of the questions and it circumvents having to identify explicitly what is problematic about the physicians’ questions.

Pattern conformity with dispreferred answer.

Q/A-AP 4:
1   R: Is that a new pain?
2       (0.7)
3   P: Ah::: (1.3) maybe it is not a new pain no. Because I have also tumour here.

Q/A-AP 5 (see Exemplar 9):
1   R: Could it be better controlled?
2       (1.0)
3   P: I don’t want to take more,
In Q/A-APs 4 and 5, the physicians’ questions display the principle of problem attentiveness and prefer yes-type answers, both of which are features that encourage elaboration. In Q/A-AP 4, R’s YNI prefers an answer in which P reports new pain. However, P gives a dispreferred answer plus elaboration that accounts for his dispreferred answer. That is, P informs R that the pain he described in a previous turn is not a new pain (as the preferred answer to R’s question would indicate); rather, it is an old or regular pain because it is located where he is known to have a tumour. P’s elaboration also implicitly informs R that given that this pain is a regular pain, it is unlikely that the pain indicates a change in or progression of his disease.

R’s YNI in Q/A-AP 5 prefers an answer that indicates that a change needs to be made to the current pain management strategy for better control of P’s experience of physical pain (referenced by the pro-term “it”). As well, R’s question implies that P may be experiencing either some new pain or an increase in his regular pain that would require a change to his current pain management in some manner (e.g., an increase in his pain medication). P provides an agenda-transforming answer that transforms the topic agenda of R’s question from his satisfaction with the pain management/control to the amount of pain medication he is taking to manage/control his pain (i.e., he addresses the implied question rather than the explicit question). P’s dispreferred, elaborated answer explicitly displays a resistance to take more medication, and implicitly communicates to R that he does not have any new pain or increase in his regular pain that requires him to take more medication.
Pattern 2. Optimized YNIs designed to prefer a yes-type answer (positively polarized) discourage elaboration (Heritage, 2010). In the present study, two YNIs Q/A-AP display conformity to this pattern and one deviates.

Pattern Conformity.

Q/A-AP 6 (see Exemplar 5):
1    R: So when you take the medication (0.3) do you have relief?
2     (1.2)
3    P: Hm: (0.4) Yeah. (0.5) It’s:: (0.9) Yeah (0.4) I have relief
4    R: °Okay°.
5     (0.4)
6 *hh I mean-
7     (0.4)
8      does it get from like
9     (1.2)
10  >does it ever get down to< zero or do you always have
11     (0.3)
12 °pain°?

Q/A-AP 7 (see Exemplar 10):
1   SP: Are you happy with where your pain control is now.
2     (1.3)
5   P: U::h:
6     (0.7)
7   SP: Or could it be better?
8     (1.0)
9   P: I think very yeah it’s okay.

Although these YNIs are optimized, which can discourage elaboration, they also contain terms that appear inapposite (Q/A-AP 6 “relief”; Q/A-AP 7 “happy”) and thus may be difficult for P to answer. Examination of the talk after the bolded Q/A-APs shows that the physicians subsequently treat P’s lack of elaboration as signaling something accountably wrong with their question. That is, in Q/A-AP 6 R’s next turn in Line 6 begins with “I mean”, indicating that the next question is a reformulation of the YNI in Line 1. She reformulates her optimized YNI into an ALT-Q that, by the nature of ALT-Qs, cannot display a preference for an answer and thus cannot be optimized. In Q/A-AP
7, SP reformulates her YNI in Line 1 into a quasi-ALT-Q in Line 7, which offers P a choice between the optimized option in Line 1 and the non-optimized option in Line 7 (see Q/A-AP 3).

**Pattern deviation.**

**Q/A-AP 8:**

1. R: Is any activity that you are **avoiding** to do because of the **pain**? (1.1)
2. P: Ah:: (0.4)
3. I am **avoid-avoiding** may be sitting for a long(h) ti(h)[me ].
4. R: [Um] hm. (0.5)
5. P: [°That's ] about it°. (0.4)
6. R: [°Okay° ] (0.4)
7. P: **Pressure** on my pelvis >ah I'm< avoiding this. (.)
8. R: °Uh huh°. (0.4)
9. P: I have to: sleep (all) usually on my::: stomach?, (0.2)
10. °so°. (0.3)
11. R: ↑O↓kay. (7.3)
12. R: So: it seems that the- the- the day (0.3) the- the pain during the da::y has been stable. (0.4) Is that [correct]? (0.4)
13. P: [Y:eah::]ah: it's it's more or less >yeah (0.2)
14. yeah< stable even during the night. It’s stable more or less.

Prior to the bolded Q/A-AP, R enquires about possible activities P is avoiding because of his physical pain (Lines 1 to 2; see Exemplar 8). P identifies sitting for a long period of time (Lines 6 to 8). He adds that he also avoids pressure on his pelvis (Line 14) and he gives an example of an instance in which he would assume a posture to avoid pressure on his pelvis (i.e., he usually sleeps on his stomach; Line 18).
R acknowledges receipt of this information in Line 22 (“Okay”) and her first TCU in the bolded Q/A-AP is a gist formulation (in the form of an assertion) of P’s prior talk and she follows her assertion with a YNI seeking affirmation for her gist formulation. R’s bolded multi-unit turn in Q/A-AP 8 is designed in a similar fashion to R’s multi-unit turn in Q/A-AP 1 (i.e., the first TCU is an assertion; the second TCU is a YNI designed to affirm the assertion); however, there is an important distinction. That is, in Q/A-AP 1 R’s subsequent YNI (i.e., “Is that correct?”) asks P for an affirmation that she read his ESAS answer correctly. Given that R’s first TCU is a repeat of P’s answer on the ESAS form, her YNI is not optimized because her gist formulation is not making an evaluation; rather, it simply repeats documented information. Therefore, it can be argued that the design of R’s multi-unit turn in Q/A-AP 1 acts like a YND seeking confirmation rather than affirmation and it discourages elaboration. P’s non-elaborated answer treats R’s YNI as a YND.

In contrast, in Q/A-AP 8 R’s first TCU begins with “so it seems” that connects her turn to P’s previous talk via the so-prefix and the evidential verb “seems” (see Heritage & Raymond, 2005). The use of this evidential verb indicates that what is to come next is an inference based on P’s previous talk. According to Heritage and Raymond (2005), evidential verbs such as looks, feels, appears, sounds, and seems work as epistemic downgrades; when a speaker includes an evidential verb in his/her turn, he/she assumes a greater K-stance (in relation to the recipient’s K+ stance) than if the speaker had made an assertion without the evidential verb. That is, with the evidential verb the speaker makes an inference (based on the recipient’s previous talk) that the recipient has significantly greater knowledge about the matter at hand. R’s subsequent
YNI “Is that correct?” requests an affirmation of her optimized evaluation of P’s previously described situation (i.e., P’s pain during the day is stable; Lines 24 to 25). P provides the preferred answer plus elaboration. The elaborated part of P’s answer works to enhance R’s inference by informing her that his experience of physical pain is, “stable even during the night”.

**Pattern 3.** Optimized YNIs that are negatively polarized (i.e., contain a negative polarity item such as *any, ever, at all*) are designed to prefer a *no*-type answer and they discourage elaboration (Heritage, 2010). In the present study, six YNI Q/A-APs display conformity to this pattern and four deviate. This type of YNI will receive some elaboration in the answer when the respondent gives a dispreferred answer (Heritage, 1984). Three of the YNI Q/A-APs that deviate from Pattern 3 contain elaborated dispreferred answers.

**Pattern conformity with preferred answer.**

**Q/A-AP 9:**
1  R: *Any chang[es ]?*
2  P: [No]

**Q/A-AP 10** (see Exemplar 4):
1  R: *Any pains?*
2  
3  P: No (0.4) not right now.

**Q/A-AP 11:**
1  R: An::d do you *ever* wake from (0.5) u:m: (.) wake in the middle of the night
2  because of pain?
3  
4  P: Mm::: no.

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77 In my analysis I do not consider the phrase “right now” in P’s answers as elaboration; rather, I treat it as a qualification to his preferred answer.
Q/A-AP 12:
1   R: **Any** any new pains in the back here?
2   (0.2)
3   P: New? (0.2) N:::o: no new.

Q/A-AP 13 (see Exemplar 3) and 14:
1 → R: Is there **any** pain in your back?, (. ) right now?
2   (0.7)
3   P: No.
4 → R: In here?
5   (0.5)
6   P: No

P’s answers in Q/A-APs 9 to 14 indicate something specific about his experience of pain: his physical pain is stable (Q/A-AP 9), he is not experiencing physical pain at the present time (Q/A-AP 10), his sleep is never disrupted because of physical pain (Q/A-AP 11), and he is not experiencing any pain in his back (Q/A-APs 12 to 14). It should be noted that all of these answers involve a claim by P that he either does not have any pain (new or otherwise) or that his pain has not changed for the worse, both of which imply that his disease is not progressing.

*Pattern deviation with preferred answer.*

Q/A-AP 15:
1   R: Has there been **any** new pain that’s come up (0.3) apart from the- your
2       regular [pain].
3   P:        [No. ] I had enough.

R’s YNI in Q/A-AP 15 is designed to prefer an answer that acknowledges that P has regular pain but not any new pain to report. P provides a preferred answer plus elaboration. The preferred answer, “No,” addresses the first part of R’s question “Has there been any new pain that’s come up.” P’s elaboration of “I had enough” is directed at

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78 Q/A-APs 13 and 14 have been combined because sequentially they are part of a routine checklist. Given that the truncated YNI “In here” follows a fully formed YNI that contains the negative polarity item “any,” it can be projected that if the truncated YNI had appeared outside of the checklist objective, it would have also contained the word “any” (“Is there any pain in here?”) (see Stivers & Heritage, 2001).
R’s add-on of “apart from your regular pain,” which acts to dismiss P’s regular pain. P’s elaboration informs R that his regular pain should not be dismissed. That is, P’s elaboration is not directed to the whole question (which discourages elaboration) but toward the specification of “pain”. This Q/A-AP is an example of the importance of considering the content of the whole question.

*Pattern deviation with dispreferred answer.*

**Q/A-AP 16** (see Exemplar 7):
1 R: U::m: (0.4) pt (0.2) an:::d (2.3) are you-do you have any pain?
2 (0.9)
3 P: Ah::: (0.3) y:eah:: I have some pain ah:: yeah: usually in my pelvis.

R’s YNI in Q/A-AP 16 prefers a no-type answer that would indicate that P had no pain. Given that it has already been established that P has pain (via his most recent ESAS form), it would be inaccurate for him to give the preferred answer. P provides a dispreferred answer plus elaboration. P’s use of elaboration provides an account for his dispreferred answer: he experiences pain usually in his pelvis.

**Q/A-AP17:**
1 R: Do you have any specific issues that you wanted to bring up?, with regards to your pain?, (0.5) this week.
2 (1.5)
3 P: M::uah:: it hasn’t changed a lot (. ) m:: (. ) m:: (0.2) in the last hm

In Q/A-AP 17, R asks an unspecified YNI with regard to the aspects of pain. R’s YNI prefers a no-type answer (because of the negative polarity item any) that indicates that P does not have pain to report at this visit. P provides a dispreferred answer; his elaboration provides an account in that he reports a slight change in his experience of pain (“hasn’t changed a lot”).

210
Q/A-AP 18 (see Exemplar 8):
1 R: Is any activity that you are avoiding to do because of the pain?
2 (1.1)
3 P: Ah:: (0.4) I am avoid-avoiding maybe (0.3) sitting for long (h) ti(h)me

R’s YNI in Q/A-AP 18 prefers an answer whereby P reports no avoidance of activities because of pain. P provides a dispreferred answer and elaboration that reports an occasion when he is affected by pain.

An interesting feature of P’s elaborated answers in Q/A-Aps 16, 17 and 18 is that P’s minimizing language stresses that even though he has pain, it is (1) not severe (“some pain”), (2) changing slowly (“it hasn’t changed a lot”), and (3) only prevents him from doing extreme activities (“sitting for long time”). These minimized answers serve to inform the physicians that although P has regular pain, it is changing slowly and still manageable; by implication, it is unlikely that his disease is rapidly or seriously progressing.

Pattern 4. YNIs designed to display problem attentiveness encourage elaboration (see Stivers, 2007). When a YNI is negatively polarized (i.e., designed to prefer a no-type answer because of the inclusion of a negative polarity item) elaboration is discouraged (Heritage, 2010). Including a negative polarity item in a problem attentive question may appear contradictory and problematic. However, according to Heritage (2010), the negative polarization of a problem attentive question “becomes a marker (among several) of the seriousness of the symptoms” (p. 51) and elaboration of the problem is warranted. In the present study, one YNI Q/A-AP displays conformity to this pattern and there are no deviations.
Pattern conformity.

Q/A-AP 19:
1   R: Does anything make it better?
2   (1.1)
3   P: U::m (1.9) no I don’t need ah:: I think anything for this.

R’s problem attentive YNI implies that P’s experience of physical pain is not being controlled by the current pain management strategy and a change needs to be made (e.g., an increase in his current medication or a prescription for a different medication). The preferred answer to R’s YNI is no (or an answer of a similar nature) because of the negative polarity item any. P provides a preferred answer in response to the negative polarity item, which alone would indicate that his physical pain has progressed to the point where he experiences pain on a constant basis. P’s elaboration rejects the speculation that (1) a change needs to be made to the current pain management plan and (2) his disease is progressing. Further, his answer works to diffuse any future recommendations for more pain medication.

Yes/No Declaratives

CA researchers (e.g., Heritage, 2010; Raymond, 2010) have identified several consistent patterns in YND Q/A-APs but only one is relevant to elaboration.

Pattern 5. The use of a YND makes relevant a confirmation from the respondent and discourages elaboration, regardless of whether the YND is positively or negatively polarized (Raymond, 2010, p. 95). In my data, 11 YND Q/A-APs display conformity to this pattern and six deviate. This type of YND will receive some elaboration in the answer when the respondent gives a dispreferred answer (Heritage, 1984). Three YND Q/A-APs that deviate from Pattern 5 contain elaborated dispreferred answers.
Pattern conformity with preferred answer.

Q/A-AP 20 (see Exemplar 1):
1  R: So it had gone up (0.3) a:t (0.2) the start of the session.=
2  P: =Y:eah.

Q/A-AP 21:
1  R: It’s alwa- you always feel it there.
2  (0.2)
3  P: Y:eah:: sometimes yeah but ah79:

Q/A-AP 22:
1  R: It’s just there.
2  (0.4)
3  P: I-ju-it’s there yeah80

Q/A-AP 23 (see Exemplar 2):
1  R: So it sounds like it’s (0.2) it the pain is:: (0.5) is well controlled.
2  (.)
3  P: M-more or less yeah it’s okay yeah81.

Q/A-AP 24:
1  R: But not jus:t normal touch.
2  (0.3)
3  P: Not normal yeah. (0.7) no

Q/A-AP 25:
1  R: So you’re able ta (0.2) ta do activities that may be you weren’t able ta do before.
2  (1.0)
3  P: Yeah-yeah-ah:-um yeah.

Q/A-AP 26:
1  R: Your pain is the same.
2  (0.2)
3  P: The same

Q/A-AP 27:
1  R: Your everyday life is less affected by the pain?
2  (1.0)
3  P: Right now it’s less.

79 As in Q/A-AP 10, I treat P’s answer as a qualification to his preferred answer, not as elaboration.
80 In my analysis I do not treat P’s answers that repeat part of the question as elaboration.
81 In my analysis I do not treat non-committal answers such as “more or less” as elaboration.
In Q/A-APs 20 to 29, P provides a report that confirms something specific about his experience of pain: his physical pain increases temporarily at the beginning of a new set of chemotherapy sessions (Q/A-AP 20); he experiences regular pain (Q/A-APs 21 & 22) but the pain is stable (Q/A-APs 24, 26 & 28) and he is currently not experiencing new pain (Q/A-APs 24, 26, 28 & 29); there is some measure of pain control (Q/A-AP 23); and his everyday life is less affected by the pain at the present time (Q/A-APs 25 & 27). It should be noted that, as in Pattern 4, all of these answers involve a claim by P that he either does not have any new pain or that his pain has not changed for the worse, both of which imply that his disease is not progressing.

**Pattern conformity with response but no answer.**

Q/A-AP 30:
1 R: So you feel like you’re- (0.2) better:: able ta ta manage the pain now?
2 (1.0)
3 P: U::m:
4 R: Your everyday life is less affected by the pain?
5 (1.0)
6 P: Right now it's less.
7 (0.5)
8 R: It's less.
9 (0.4)
10 Okay.
11 (0.5)
12 So you're able ta
13 (0.2)
14 ta do activities that may be you weren't able ta do before.
15 (1.0)
16 P: >Yeah-yeah-ah:-u:m< yeah.
R’s YND in the bolded Q/A-AP assigns P the agency with regard to the management of his pain (i.e., “you’re better able to manage the pain”). After a lengthy pause of 1.0 seconds, P provides a response but not an answer. With regard to elaboration, P’s response conforms to Pattern 5 (i.e., he does not elaborate beyond his simple response). P’s response indicates that he finds something problematic about R’s YND. It is possible that the incomplete comparison in R’s question (i.e., “better able to manage the pain now” as opposed to when? Since his last visit, a medication change, his last chemotherapy treatment, etc.) could account for P’s non-answer.

R subsequently treats P’s non-answer as signaling something accountably wrong with her question. Consequently, she quickly shifts the subject of her question from P (“you”) to a life less impacted by the pain (“your everyday life”; Line 4). P provides the non-type-conforming, preferred answer (i.e., the answer does not include yes or no, but “it’s less” essentially acts the same as a yes) to R’s subsequent YND, qualifying his answer to the present time (“right now”). It is possible that P’s non-answer in Line 3 indicates that P finds it problematic to be enrolled as the agent who is responsible for managing his pain and he is better able to respond when he is enrolled as a commentator/reporter on his life.

Pattern deviation with preferred answer.

Q/A-AP 31:

1 P: I’m not feeling worse?, (1.2) I I would say ah: (1.0) n:-no changes since the last
time.=
2 3 R: =↑O↓ kay. (0.2)
4 In terms of the pain?, there’s no change.
5 (.)
6 P: U::m (.) I don’t zink so no no it is not worse.
R’s bolded YND in Q/A-AP 31 (Line 4) prefers a no-type answer that would indicate an optimized outcome that P’s pain is stable. P defers his preferred answer with the epistemic downgrade “I don’t zink so” before he ratchets up the epistemic certainty by repeating the preferred answer of “no” twice then adding the elaboration “it ((his pain)) is not worse.” P’s elaboration changes the topic from generic change to the matter of worsening pain. The emphasis on P’s pain as “not worse” may imply a possible change for the better, which is in line with the optimism displayed in Line 1 in which he states that he is not feeling worse and that there is no change since his last visit (no change is considered an optimal outcome in a palliative context). Further, by stating explicitly that his pain is “not worse”, P implies that his disease is not progressing.

Q/A-AP 32:
1 R: When we look at your (0.3) your u:m: pt symptom assessment (.) report (0.5) u:m (.) your pain is constant. It was (0.2) two the last time, it’s two this time. (0.2)
4 .hhh U::m: (1.0) but you (.) seemed >to have< (0.3) <been: more> aggressively showing (0.6) ah::: just the symptoms were (.) a-or may be more so there the last time. >That could< just be:: (.) how you were drawing but, (0.5)
7 P: >I-I-I< just ah:::: (1.1) I just (0.2) u::: (0.2) draw the area more or less i-i-it doesn’t mean that i-it intensity. Yeah.

R’s multi-unit questioning turn in Q/A-AP 36 reminds P that his report of the severity of his pain (on the one to 10 scale) is the same for the two most recent ESAS forms he completed. Then she informs him that his indication of where the pain is located is drawn more aggressively on his current ESAS as compared to his previous form (implying that his pain has intensified). R’s YND provides P with a candidate explanation for the apparent discrepancy in his indication of pain, preferring an answer that the discrepancy is a drawing difference and not a difference in intensity of pain. P’s deferred, preferred answer agrees with R’s interpretation that the difference in drawing is not
related to an increase in the intensity of his pain. As in Q/A-AP 31, P’s elaboration informs R that his pain is stable and by implication, that his disease is not progressing.

**Q/A-AP 33:**
1. R: Okay it’s both legs::?
2. (0.5)
3. P: B-both legs but more (. ) more the right one.

R’s YND in this Q/A-AP prefers an answer that indicates that P has pain in both legs. The design of R’s YND displays a lesser K- stance than if she asked a YNI because she presupposes to know that P has pain in both legs, rather than being uncertain of this information and asking him. P’s non-type-conforming (i.e., he gives a partial repeat instead of answering with *yes* or *no* or some equivalent), preferred answer confirms R’s YND; however, P’s partial repeat of R’s question indicates that P finds something problematic about R’s question and his elaboration identifies the problem. That is, P’s partial repeat addresses the epistemic stance issue by elevating his K+ epistemic stance to significantly greater than R’s (see Stivers, 2005) and his elaboration challenges the presupposition in R’s question (see Heritage, 2010) that the pain is equal in both legs by informing R that he has more pain in the right leg.

In summary, analyses of these exceptions to Pattern 5 suggest a basis for the deviations from the usual pattern. First, it is possible that enrolling a recipient as the agent who is responsible for a component of the speaker’s position may contribute to the recipient answering in a manner that is contrary to the expected elaboration. The recipient may be better able to answer when he is enrolled as a commentator/reporter on the topic. Second, if a preferred answer does not fully capture the extent of the situation, a recipient may choose to add elaboration to avoid misunderstandings (e.g., to reinforce the
unlikelihood of a potentially negative situation such as disease; to correct an inaccurate presupposition).

**Pattern deviation with dispreferred answer.**

**Q/A-AP 34** (see Exemplar 6):
1   R: Does it- it’s not painful.
2    (0.7)
3   P: Not painful: ah:: but it is different in some (respect). MAY BE A BIT More painful if you:: something like do something like this?, ah

R’s YND in this Q/A-AP prefers an answer that indicates that the physical sensation that P has described is not painful. As noted in Exemplar 6, P provides the preferred answer and then he changes to the dispreferred answer and adds elaboration to account for the change. As well, in his elaborated answer P downplays an increase in pain, implicitly discounting the possibility that this change in his pain is related to a progression of his illness.

**Q/A-AP 35:**
1   R: And your pain is:: (1.0) m:: (0.2) about the same it sounds like
2    (0.9)
3   P: This- (0.2) now it is different.

R’s YND in this Q/A-AP prefers an answer that indicates that his pain is stable. P provides a dispreferred answer that informs R that his pain has changed in some respect, but the ambiguity of “different” downplays the report of change. That is, different does not indicate if his pain is worse or better, just that it is not the same.

**Q/A-AP 36** (see Exemplar 21):
1   R: >And so< your perception is that (0.4) the pain has been CONstant. It hasn’t (0.4) decreased or it hasn’t increased (0.2) in with this last session?=
2   P: =>Yeah yeah it< increased when: they began (the new) chemo?,

R’s YND in Q/A-AP 35 prefers an answer that indicates that P’s pain has remained stable during his latest chemotherapy treatments. P’s dispreferred answer plus
elaboration revises R’s gist formulation to the more accurate report that his pain increased (past tense) when the chemotherapy began. P’s past tense and stipulation that the increase was limited to the beginning of the chemotherapy sessions, informs R that the increase in his pain was temporary and that his experience of pain decreased after this point.

**WH-Questions**

CA researchers (e.g., Fox & Thompson, 2010; Heritage, 2002) have identified some consistent patterns in WH-Q Q/A-APs but only two are relevant to elaboration. As noted previously, WH-Qs do not demonstrate a bias or preference for a specific answer (see Boyd & Heritage, 2006); therefore, this will not be considered in the analysis of elaboration.

**Pattern 6.** *What, why and how* questions are telling questions that encourage elaborated answers (e.g., reports, stories) (Fox & Thompson, 2010; Heritage, 2002). In the present study, three *how* and two *what* Q/A-APs display conformity to this pattern and two (one *how* & one *what*) deviate.

**Pattern conformity.**

**Q/A-AP 37** (see Exemplar 11):
1 R: U::m::: so couple things I wanna know is how is your pain.
2 (1.3)
3 P: U:m (2.0) I still have pain. (0.5) Yeah. (1.5) U::m (0.3) but I having better that it’s stopped growing in my::: ah::: ah: my pelvis (0.2) Cuz I had radiation.

**Q/A-AP 38:***
1 R: How is your::: (.) pain after this last chemo session?
2 (1.2)
3 P: It hasn’t changed ah:: (0.7) I dunno. (0.2) With this new chemo I: I usually ah (.) I:::-I have more pain::, especially in my pelvis.
Q/A-AP 39:
1 R: Tell me how your pain’s different.
2 (1.1)
3 P: It’s always something like present but it is something like different. I don’t know how. But it was different before?

Q/A-AP 40:
1 R: What does worked mean for you. That the [radiation]
2 P: [Ah:: it’s ] stopped (0.6)
3 stopped pressing my nerves.

Q/A-AP 41 (see Exemplar 12):
1 R: And so Instead of the having the pain pressing on your nerves what’s the pain feel like now?,
2 (2.4)
3 P: Now: how it’s like present ah-i it’s present.

In Q/A-APs 37 to 41, P provides a report that highlights something specific about his experience of pain: he still has pain but it has improved (Q/A-AP 37); his pain increases at the beginning of chemotherapy treatments (Q/A-AP 38); his physical pain is present but it has recently changed in some way (Q/A-AP 39); his understanding of the chemotherapy working is when the tumour in his pelvis stops exerting pressure on his nerves (Q/A-AP 40); and his pain is present (Q/A-AP 41).

Pattern deviation.

Q/A-AP 42 (Exemplar 14):
1 R: And how much of the medication are you currently taking?
2 P: Ah two pills of oxycotton ten milligrams.
3 R: Okay. And how is that helping your pain?
4 (0.7)
5 P: Ah it’s ah yeah it’s more or less okay yeah.

Prior to the bolded Q/A-AP, R asks P how much pain medication he is taking (Line 1). P informs R of the type and amount of medication he is taking for his pain (Line 2). R acknowledges this information with “Okay” before she asks P the how question in Line 3. As noted in Exemplar 14, the topic of R’s how question is ambiguous and it
seems out of place considering the previous Q/A-AP in Lines 1 to 2. That is, it would have been more appropriate for R to ask an optimized YNI such as “Is that helping?” P’s answer closely resembles a *yes* answer to such a YNI. The ambiguous topic of R’s question and the inapposite *how* likely contribute to P’s production of the abbreviated, non-committal answer. P’s answer allows him to provide an answer on topic and to avoid a depreciatory evaluation of R’s question.

**Q/A-AP 43:**
1  R: What is the pain?
2     (1.2)
3  P: What?

Generally, a *what* question makes relevant an elaborated description of an event, place or person (Heritage, 2002). R’s *what* question in Q/A-AP 43 is grammatically malformed in that it asks for a description of what “the pain” is. P’s turn asks for clarification regarding this question (i.e., he repeats the “what” component of R’s question with rising ending intonation to indicate a query). P’s response deviates from Pattern 6 because he does not elaborate. Q/A-AP 45 (see below) follows sequentially after Line 3 of Q/A-AP 43.

**Pattern 7.** *Who, when* and *where* questions are specifying questions that seek specific pieces of information and encourage a concise answer with little elaboration (Fox & Thompson, 2010; Heritage, 2002). In the present study, one *when* Q/A-AP displays conformity to this pattern and one *where* Q/A-AP deviates.

**Pattern conformity.**

**Q/A-AP 44** (Exemplar 13):
1  R: When when when do you notice it.
2     (0.9)
3  P: When:? I always notice it.
In this Q/A-AP, P provides a specific answer (“always”) that addresses the when component of R’s question.

**Pattern deviation.**

**Q/A-AP 45:**

1. R: What is the pain?
2. (1.2)
3. P: What?
5. P: [Where?]
6. =Ah (0.3) it’s usually in my pelvis and ah:: yeah it’s usually in my pelvis.
7. (0.8)
8. So I have some like unusual feelin from the outer side of my legs and my
9. feet.

As stated in the analysis of Q/A-AP 43, P’s turn in Line 3 asks for clarification regarding R’s initial what question (Line 1). R clarifies by first saying “Where,” which requests a specific body location, and then with a reformulation of the earlier what question that in this context is equivalent to a where question (i.e., “What part of your body” requests an answer that specifies a body location). P’s answer deviates from Pattern 7; his elaboration reports a new sensation in his legs and feet.

**Alternative Questions**

CA researchers (e.g., Koshik, 2005; Stivers, 2010) have identified a few consistent patterns in ALT-Q Q/A-APs but only one is relevant to elaboration. ALT-Qs do not demonstrate a particular preference for one option over the other (see Bolinger, 1957, as cited in Koshik, 2005); therefore, this will not be considered in the analysis of elaboration.

**Pattern 8.** The use of an ALT-Q makes relevant an answer in which the respondent repeats one of the provided answer options and elaboration is discouraged.
(Koshik, 2005; Stivers, 2010). In the present study, none of the ALT-Qs conform to this pattern; rather, the four ALT-Qs deviate from the pattern.

Q/A-AP 46:

1. R: Where does it hurt the most in your back. (0.5) Or [in your pelvis].
2. P: [In my back it’s usually not. It’s like ah pelvis ah::: (0.2) more here from the right side.

R’s ALT-Q in Q/A-AP 46 asks P to choose between a report of more pain in his back or his pelvis. P’s elaborated answer addresses his experience of pain in both locations; he states that he usually does not have pain in his back and the pain in his pelvis in more prevalent on the right side. The most likely explanation for P’s elaborated answer is that R pauses 0.5 seconds before saying “or” and offering the second answer option. P initially addresses the first option in overlap with R’s production of the second option indicating that he interpreted R’s pause before the second answer options as a TRP (i.e., a place where a change of speakers can take place). In effect, P does not treat R’s question as an alternative question; rather, he treats the first part of the question as a where question. However, P’s response does not answer the where component of R’s ALT-Q with the expected identification of a location; rather, he rejects the inherent presupposition in the question that he has pain in his back (“In my back it’s usually not”). He then goes on to provide an answer to the second part of R’s question (“Or in your pelvis”) with an answer that conforms to Pattern 7 (i.e., a specifying answer to a where question).

Q/A-AP 47 (see Exemplar 15):

1. R: And when you say unusual is: it: is: more painful or is (0.3) feel different? 
2. P: [As in] feel different ah:: (0.2) not normal feelin, because here for example is everysing normal as it was before the cancer.
R’s ALT-Q in Q/A-AP 47 asks P to choose between painful or different as a substitute for his earlier description of unusual. P repeats “different” to signify this as his selection and he provides an elaborated answer as an explanation for the ambiguous descriptor.

**Q/A-AP 48** (see Exemplar 16):
1 R: I mean- (0.4) does it get from like (1.2) does it ever get down to zero or do you always have (0.3) pain?
2 (0.7)
3 P: Ah:: (0.2) I have pain more when when I am sittin.

R’s ALT-Q in this Q/A-AP asks P to choose between not experiencing pain to always experiencing pain. As noted in Exemplar 16, P’s answer most likely indicates that he rejects both answer options as inappropriate (i.e., they are both extreme case formulations and neither option accurately describe his situation).

**Q/A-AP 49** (Exemplar 20):
1 R: In FACT You ranked it as: a little even bit better than the last time ar-around, >do you think that that’s the truth?, < or somewhere (hh)huh probably about the same.=
2 P: =It could be yeah::.

R’s ALT-Q in Q/A-AP 49 asks P to choose between a challenge to the accuracy of his most recent report of pain on the ESAS form and R’s candidate correction that his pain is the same (implying that his report on the ESAS form is untrue). P provides a non-committal answer. Given that selecting either one of the options would indicate that P was untruthful in his report of pain, it is likely that he rejects both answer options as inappropriate. That is, if P picks the first alternative (that his description of his pain on the ESAS form is “the truth”) it would mean that his earlier verbal report of his pain being the same as last time was false; if P picks the second alternative (that his pain is the same as last time) it would mean that his report on the ESAS form was incorrect.
Therefore, given that choosing one of the answer options would be self-depreciatory, it is understandable that P’s non-committal answer avoids a negative evaluation of the inapposite component of R’s question.

In summary, analyses of these exceptions to the pattern suggest some explanations for the deviations. First, if the answer options are not offered as a continuous turn (i.e., there is a sizeable pause before the second option is offered), respondents may treat the first option as a YNI and answer that before or during the speaker’s presentation of the second answer option. Addressing also the second part of the ALT-Q will result in an elaborated answer. Second, ambiguity in the meaning of one of the answer options may result in the respondent elaborating to explain the ambiguous option if it is chosen. Third, if the respondent rejects both answer options as inappropriate because selecting either of them would be self-depreciatory, it is possible that the respondent will provide an elaborated and/or non-committal answer that avoids self-depreciation and depreciation of the question design.

**Multi-Unit Questioning Turns with Two Questions**

Questioning turns that contain two questions occur twice in the dataset. Currently, there is no published CA literature that discusses whether elaboration is encouraged or discouraged when questioning turns contain more than one question.

**Q/A-AP 50** and **Q/A-AP 51** (see Exemplar 18):

<table>
<thead>
<tr>
<th></th>
<th>R: And how is the pain now: Is:: ah:: is:: that</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>[bothersome::e &gt;after you stop it&lt;]</td>
</tr>
<tr>
<td>2</td>
<td>P: [ Ah it’s more or less okay ] ah::: more [or less]</td>
</tr>
<tr>
<td>3</td>
<td>R: [Any chang[es ]?</td>
</tr>
<tr>
<td>4</td>
<td>P: [No].</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

R’s turn in Lines 1 and 2 involves her asking a *how* question (Q/A-AP 50) immediately followed by a YNI (Q/A-AP 51). As stated in Pattern 6, R’s *how* question is
a telling question that encourages an elaborated answer, and as stated in Pattern 1, R’s non-optimized YNI prefers a yes-type answer and encourages elaboration. To the how question P provides a non-committal answer that deviates from Pattern 6 because he does not elaborate. P’s non-committal answer to the how question is delivered in overlap with R’s YNI. He does not respond to the second question; his talk in overlap with the question effectively deletes it. R accepts P’s deletion when she asks the YNI “Any changes?” (Line 4) in overlap with P’s non-committal answer to the how question. In P’s next turn (Line 5) he gives the preferred answer to R’s YNI (see Q/A-AP 9).

Q/A-AP 52 and Q/A-AP 53 (see Exemplar 19):
1 R: And is it an achy pain? (0.2) Is it (0.2) something that (0.5) is kind of always (0.2) always there?, Does it come and go::?,
2 (1.1)
3 P: Mine is always there.

R’s turn involves her asking a YNI (Q/A-AP 52) closely followed by a quasi-ALT-Q (i.e., R produces the effect of an ALT-Q without using or - Q/A-AP 53). R’s non-optimized YNI prefers a yes-type answer and encourages elaboration (see Pattern 1); the ALT-Q discourages elaboration (see Pattern 8). P does not answer the YNI question (deviates from Pattern 1) and he conforms to Pattern 8 by repeating one of the answer options to the quasi-ALT-Q. Given that R does not repeat or pursue an answer to her YNI, she communicates to P that his answer to her quasi-ALT-Q is sufficient. In effect, she treats the YNI as a deleted question.

In summary, it may appear problematic when Q/A-APs that contain two questions in the questioning turn receive an answer to only one of the questions; however, this might not be the case when the sequential organization of the subsequent talk is examined. That is, if the talk subsequent to the Q/A-AP shows that the question that is
not addressed in the respondent’s answer is deleted by one or both of the participants, the questioning turn is not problematic for the participants.

**Summary**

In the present study, I analyzed 53 of the 58 physicians’ questions. Sixteen questions were designed to encourage elaboration, yet only eight of these received an elaborated answer (two of which involved dispreferred answers). There are three explanations for the eight deviations from the expected patterns: question design problems, content issues, and the problem of double-question turns. First, questions whose design usually encourage elaboration may nonetheless have features that discourage elaboration, for example, when they are designed to make relevant a confirmation rather than an affirmation or when they are malformed questions that require clarification. Second, the inclusion of inapposite terms in questions can contribute to the production of answers/responses that are contrary to the expected elaborated answers because the topic of the question becomes ambiguous. Finally, the two double-question multi-unit turns contained three questions that were designed to encourage elaboration and none of the questions received an elaborated answer. Rather, P provided a non-committal answer to one of the questions and two of the questions were oriented to by the physician and patient as deleted questions when examined sequentially with subsequent talk. It is possible that the double-question environment, in conjunction with overlapping speech, places restrictions on elaboration, especially when both interlocutors display orientation to a deletion of one of the questions.

Thirty-seven of the physicians’ questions discouraged elaboration, yet 16 received elaborated answers. There are three explanations for the deviations: the requirements of

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82 See Table 2.
dispreferred answers, question design problems and content issues. First, six deviations from the usual patterns of non-elaboration were understandable as accounts for dispreferred answers. Second, ALT-Qs that usually discourage elaboration can be answered in a manner that is contrary to the expected non-elaboration when the answer options are not offered as a continuous turn (i.e., there is a sizeable pause before the second option is offered). That is, respondents may treat the answer options as separate questions and answer in a manner that conforms to the expected elaboration of one or both of the answer options. Finally, there can be content problems with the question. As with questions encouraging elaboration, inapposite terms and/or ambiguous topics can contribute to the production of answers/responses that are contrary to the expected answers. Also, inclusion of dismissive or inaccurate content in the questions may contribute to answers contrary to expected non-elaboration when the respondent addresses the specific problematic component of the question.

General Chapter Summary

In this study I analyzed 44 of the 4983 questions in the single-unit turns and nine questions in the seven multi-unit questioning turns. Analysis of the physicians’ questions using the four dimensions of question design (i.e., action and topic agenda, presuppositions, preferences and epistemic stance) showed that the majority of the time P conformed to the action and topic agendas of the questions. In the instances in which P did not conform to the agendas, his answers/responses usually indicated that he rejected not only one or both of the agendas but also some other dimension of the question design (i.e., one or more of the inherent presuppositions, the preference structure of the question, and/or a physician’s attempt to appear more knowledgeable about P’s experience of pain,

83 See Table 2.
i.e., epistemic stance). In the instance of epistemic stance, P’s non-type-conforming, dispreferred answer claimed greater K+ epistemic stance and social entitlement over the relevant information about his experience of pain than the question design afforded.

Sixteen of the 38 physicians’ polar question displayed the principle of optimization (i.e., the optimal health outcome was that the patient’s pain was stable). The patient accepted the optimized design for ten of these questions. For the other eight optimized questions, the optimal health outcome was no pain. The patient accepted the optimized design for six of these questions, but displayed that there was some problem with these questions. Fourteen of the physicians’ 38 polar questions, 8/9 of the WH-Qs and 4/4 of the ALT-Qs displayed the principle of problem attentiveness.

The physicians used several devices in the design of their questions that facilitated progressivity of the talk and cohesiveness in the consultations. Devices included: (a) and-, and so-, so-, and I mean-prefaced questions; (b) the routine checklist objective; (c) gist formulations; (d) upshot formulations; (e) evidentials such as it sounds like; (f) pro-terms such as ‘it’; (g) partial modified repeats of components of the patient’s prior turns in their questions; (h) elongation of sounds in words to display continued occupancy of the turn spaces to make the patient’s non-responses at the TRPs less noticeable; and (i) self-initiated, self-repairs that caused a brief interruption in the progressivity of the talk to clarify the referent for the pro-term it before proceeding with the turn. On one occasion the patient’s answer connected his turn to prior talk even though the physician’s new topic question did not lexically connect her question to prior talk with a device such as a so- or and-preface.
Both the physicians and the patient used some deictics (e.g., *there, here*) and physical gesticulations (e.g., pointing) in their talk to refer to the patient’s physical pain. In some cases during history-taking a deictic used by the physician referred to a particular site P had indicated in his talk in the just prior turn. On several of the occasions that were visible on the video the patient used both a deictic and a physical gesture (e.g., rubbing the area to which he was referring) when indicating a pain site. Also, in some instances the patient used only physical gestures when giving answers. Overall, deictic and physical gestures by the physicians and the patient occurred sparingly during the talk regarding the patient’s physical pain.

Analysis of the patterns of elaboration in the questions and answers indicated that 16 questions (of the 53 – 30.2%) were designed to encourage elaboration and eight of those 16 (50%) received elaborated answers. Answers/responses contrary to the expected elaborated answers could be understood in terms of question design problems, content issues, and the problem of double-question turns. Analysis of the 37 questions (69.8%) designed to discourage elaboration in P’s answers indicated that the 15 answers/responses (40.5%) contrary to the expected non-elaborated answers could be understood in terms of dispreferred answers, question design problems and content issues.

Examination of the type of information that P provided in his elaborated answers indicated that he (a) reported some details about an increase in his physical pain when answering questions regarding effects of treatments (i.e., chemotherapy and radiation); (b) used minimizing language to report details about stable pain or a decrease in pain when answering questions that implied disease progression; (c) discouraged or declined

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84 As noted previously, the limitations regarding visual access to the entire consultations made consistent examination of physical gestures impossible.
offers of medication; and (d) gave non-committal, hedged or transformative answers or responses rather than answers to questions that enquired about his satisfaction with the pain control plan recommended by the physicians.
Chapter 6: Discussion

I first discuss my findings as they relate to my main research question. I then consider their relevance to the physicians’ talk during the feedback sessions that construct the interactions with the patient as being “difficult.” Next, I compare my CA findings in this palliative care setting with other CA medical research findings and take up the limitations of my research. I then discuss the implications my results may have for palliative care practice and training. Finally, I offer possibilities for future research.

Research Questions

The main research question I posed was: How do palliative care physicians use questions to assess the palliative patient’s experiences of physical pain and how does the patient respond? Addressing this question involved answering the following sub-questions.

Existence and Aspects of Physical Pain in Questions and Congruence of Answers

The first two questions I sought to answer were: What aspects of physical pain do the physicians enquire about? How well do the aspects of pain included in the patient’s answers align with those in the physicians’ questions?

My inductive analysis of 53 of the physicians’ questions identified three main groups relevant to the assessment of pain: existence of pain (see Table 1), non-specific questions about aspects of pain (see Table 2), and specific aspects of pain (with 10 sub-groups: effects of treatment, consequences of pain, quality, frequency, site, severity, new, time, occasions and management/control) (see Table 3). Although questions designed for a no-pain answer were relatively infrequent in the data (i.e., 9 of 53 total questions) it is

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85 The physicians asked a total of 58 questions, but five questions were not analyzed in the present study (see Table 2).
important to consider the implications of questions of this nature in a palliative care context.

The Clinic provides services specifically to patients with life-limiting illness and there is an expectation that patients’ physical condition will progressively worsen and their pain will change. Further, the supervising physician of the Clinic informed each resident prior to the patient consultations that there should be an assumption that patients who attend the Clinic have pain. Questions designed for a no-pain answer (with the exception of no new pain) may thus be inconsistent with the mandate of the Clinic. Asking the patient a question designed for a no-pain answer put the onus on him to provide a dispreferred answer to report pain. The patient in the present study gave a dispreferred answer to only two of the nine no-pain questions. However, the preferred answers were marked by devices such as qualifications and delays suggesting that there might be something problematic about the questions. Further, sequential analysis of the talk showed that on a few occasions the patient initially aligned with the physicians’ assumption of no pain to report, yet later in the consultation he reported some pain in response to a question that encouraged such a report (e.g., a how question). This is not to suggest that all no-pain questions are problematic or inconsistent with the mandate of the Clinic. Questions about no new pain are consistent. No-pain questions asked during the examination may be consistent with the mandate depending on the patient’s diagnosis. However, no-pain questions asked outside of the examination (e.g. at the beginning of the consultation) are inconsistent with the assumption that the patient has pain. Whether or not no-pain questions are problematic also depends on the patient’s current medical condition.
Research has found that: (a) even with an emphasis on pain management, approximately 30% of palliative care patients continue to tolerate physical pain that causes significant discomfort (Meuser et al., 2001); and (b) patients with cancer often minimize their experience of pain to conceal disease progression (Rogers & Todd, 2010). There is thus a distinct possibility that some palliative patients may not report pain when asked a no pain question. The patient in the present study often minimized his experience of pain and displayed stoicism and troubles-resistance that conveyed an unwillingness to readily acknowledge that he was experiencing pain. Asking him questions designed for a no-pain answer constructed an environment wherein he could remain more resistant to reporting changes in his pain than when he was asked questions that made relevant a report of pain. On several occasions the physicians pursued additional information from the patient after he reported pain. At these times they designed their questions to make relevant answers that report pain, thus conveying troubles receptiveness (i.e., a willingness to hear troubles talk; see Jefferson, 1988) and encouraging the patient to disclose information about his experiences of pain.

Patients’ reports of pain and no pain in palliative care contexts also are linked to the use of the Edmonton Symptom Assessment Survey (ESAS; see Appendix C). As previously noted, patients complete the ESAS prior to every consultation. The physicians compare patients’ answers on the most recent ESAS form to the previously completed forms as a way of evaluating the progression of patients’ experiences of the symptoms. Considering that the instructions on the form state that a zero indicates “no pain,” a report of a number above zero should indicate at least some pain. In the present study, the patient reported a number above zero at every consultation (reporting either a three or
four). This should indicate that he has some pain; therefore, asking him no-pain questions would appear inappropriate. According to Stivers (2007), if a patient mentions a particular symptom (either during the pre-consult with the nurse who then puts the information on the patient’s chart or on some document the physician has access to at the time of the consultation), the physician should design questions that are broadly in line with that symptom and that are designed to make relevant an answer that there is a problem (i.e., display the principle of problem attentiveness). However, whether questions designed for a no-pain answer are inappropriate because of ESAS ratings showing pain depends on how the ratings are interpreted.

Gill, Daines, and Selby (2010) conducted research looking at the discrepancies between the number patients assigned to their symptoms on the ESAS and the words (i.e., none/mild/moderate/severe) they used to describe the numbers. The researchers found that for the symptom pain the numeric range for the word none was 0 to 3, mild was 0 to 8, moderate was 1 to 10, and severe was 6 to 10. These findings indicate that there is a significant discrepancy between patients’ interpretations of the numerical values on the ESAS and physicians’ interpretations that are based on the scale instructions. The authors stress the importance of using the numeric ratings on the ESAS as a “guide for further exploration…of a patient’s symptom experience, particularly for the categories of ‘mild’ and ‘moderate’” (Gill et al., 2010, pp. 436-437). The finding that patients in the study interpreted the word none numerically as 0 to 3 has an interesting implication for the use of questions designed for a no-pain answer in the present study.

The patient in the present study reported a three for pain on his ESAS at four of the five consultations. It is possible that the patient was interpreting the number three as
not significantly different from no pain (e.g., an ache). The supervising physician at the palliative Clinic explained to one resident that she learned from experience that sometimes a patient reports an increase in the numeric value he or she assigns to his or her pain on the ESAS from one visit to the next, but the patient states verbally that his or her experience of pain was less than the last time. The supervising physician emphasized that it was important to interpret the ratings on the ESAS in the context of how the patient was doing. Therefore, it would be helpful to clarify the patient’s interpretation of the ESAS rating the first time it is completed and at the beginning of each subsequent consultation to ensure consistency in interpretation. This could be accomplished via questions that invite the patient to talk about their experience of pain (e.g., “How is your pain since your last visit?”) (see Clemente et al., 2008). These types of questions foster an environment in which patients can provide details about their pain or even a report of pain, which in turn can assist physicians in understanding patients’ interpretation of their pain in relation to the numeric value they assign pain on the ESAS.

The finding that the physicians asked non-specific questions about the aspects of pain shows an understanding that the patient may have a personal agenda for the consultations. It also displays that the agenda of the physician is to elicit a detailed, rich reporting of pain symptoms from the patient. These questions afforded the patient the opportunity to talk about the aspects of his pain that were most relevant to him at that time (see Clemente et al., 2008). However, asking him non-specific polar questions (i.e., YNIs or YNDs) that presupposed that his pain was stable (e.g., “Your pain is the same”) resulted in him pitching his answers at the same level of generality as the question (e.g., “The same”). This in turn required the physicians to follow up with more specific
questions about the patient’s pain. In contrast, the non-specific how questions (e.g., “How is your pain?”) occasioned more detailed answers about the patient’s experience of pain, especially when asked near the beginning of the consultations. It appears that non-specific how questions about pain operate in a similar fashion to How are you feeling? questions asked at the beginning of physician-patient consultations (see Robinson, 2006). That is, these questions convey to the patient that the physician is receptive to hearing the patient’s troubles telling before history-taking and the physical examination; however if they are delivered later in the consultation these questions appear out of place and occasion less detailed answers.

The finding that the physicians in the present study asked a wide variety of questions about numerous aspects of the patient’s experiences of pain shows that they view pain as a complex construct that needs to be assessed from multiple angles. Also, this finding indicates that these physicians, who were versed in the PQRST mnemonic to assess patients’ physical pain (see Chapter 1), for the most part used the mnemonic as described in the literature (i.e., a general guideline that should be adapted to fit specific contexts). The congruency of the majority of the patient’s answers to questions that asked about a single aspect of pain displayed the patient’s orientation to this type of assessment style for physical pain. The finding that the patient’s answers were unlikely to be congruent when the physicians asked a question that enquired about more than one aspect suggests that simplicity in question content is more likely to occasion answers that address aspects of pain.

The questions about the consequences of pain and effects of treatment are concerned with the ways in which the patient’s pain, and the physicians’ efforts to treat
the pain, impacted the patient’s quality of life on a day-to-day basis. This is consistent with a goal of palliative care in which physicians should strive to assist patients to experience an optimal quality of life (see Twycross, 2002). The questions about the quality, frequency, site, severity, new, time and occasions of the patient’s pain display the physicians’ efforts to map the progression (or lack thereof) of the patient’s disease (see Barnard & Gwyther, 2006). That is, monitoring the changes in the patient’s pain allows the physicians to determine if: (a) the patient’s condition is stable, improving or deteriorating; and (b) if the current pain management plan is appropriate or if it needs to be altered.

The questions that made relevant an answer that evaluated the physicians’ pain management plan demonstrate the physicians’ efforts to determine patient satisfaction. This is a valuable finding as it shows the physicians’ commitment to patient satisfaction and improving the quality of services. However, the patient’s non-committal and transformative answers convey an unwillingness and possible discomfort with providing an explicit evaluation of the physicians’ services, and in turn, their level of competence. Research has shown that in palliative care contexts patient satisfaction is “a very difficult concept to measure…as patients place tremendous faith in the treating clinician and may be reluctant to criticise practice in case it jeopardizes their treatment or care” (Shillings, Jenkins, & Fallowfield, 2003, p. 600). While it is important to evaluate patient satisfaction with care in this context, the present study found that explicit requests for evaluation do not occasion useful feedback.

86 The patient included the non-committal component of “more or less” in his answers to six of the physicians’ questions: four questions about changes (or lack thereof) in his experience of pain that were sequentially linked to talk about his satisfaction with the pain management plan and two questions explicitly about his level of satisfaction with (or perceived efficacy of) the pain management plan.
In Chapter 1, I described the CA research by Lutfey and Maynard’s (1998) that examined how a physician and his patient talked about the sensitive topic of death and dying without using those words. In the same way that CA was used in this research to access talk about a sensitive topic, it could be used as a method for obtaining information about patient satisfaction rather than explicitly asking for an evaluation. That is, sequential analysis of palliative care consultations via CA can display patients’ satisfaction with the quality of services provided without putting patients on the spot to explicitly assess the type of care received (see Beach & Anderson, 2003; Hutchby & Wooffitt, 1998; Maynard & Heritage, 2005). A detailed analysis of the displays of patient (dis)satisfaction with services was beyond the scope of the present study; however, Example 1 can offer some insight into the ways in which CA can be used to address questions of patient satisfaction:

Example 1:

1  R: Okay.
2    (0.2)
3  \(\rightarrow\) So it \underline{\text{sounds like it's:}}
4    (0.2)
5  it the pain is:
6    (0.5)
7   \underline{\text{is well controlled.}}
8    (.)
9  P: \(\rightarrow\) M-[more or less]=
10 R: \[Hm:: or less\]
11 P: \(\rightarrow\) =yeah it's okay [yeah].
12 R: \[Okay\].
13    (0.4)
14 Could it be better \underline{\text{controlled?}}
15    (1.0)
16 P: I don't \underline{\text{want to take more,}}
17    (0.5)
18 R: °pt° \text{\footnotesize{\textsuperscript{1}O;}kay.}
19    (0.6)
20 P: °°hm°°
21    (0.3)

\(^{87}\) As previously stated in Chapter 1, a strength of CA methodology is that the rich analytic detail provided in CA research can inform healthcare professionals and researchers about such topics as patient satisfaction with services.

\(^{88}\) This segment was previously analyzed and reported on pages 111-116 and 136-140.
In Example 1 the physician’s YND “So it sounds like it’s it the pain is well controlled” (Lines 3 to 7) makes relevant an answer from the patient that he views the pain management plan as effective. The patient’s non-committal answer (“more or less”; Line 9) gives little evaluative information. Examination of the subsequent talk shows that the patient is willing to accept the current pain management plan (“it’s okay”; Line 11), but his admission that he still has pain (“I can stand this ((the pain))”; Line 38) tells us that the pain management plan is not completely effective. The patient’s apparent unwillingness to acknowledge that the pain management plan has effectively controlled his pain may indicate (a) that he is not highly dissatisfied with the pain management service, but the service could be improved to better meet his pain management needs; or (b) a low expectation that such pain control is possible. Another way that patient (dis)satisfaction can be assessed without explicitly asking is to design questions that
make relevant answers that report pain. In this case, a report of pain indicates that the pain management services are in need of improvement. In contrast, a dispreferred answer that reports no pain is likely to be accompanied by an account (see Heritage, 1984), such as a report that the current pain management plan is helping the pain (but due to the nature of the palliative context, may not be eliminating the pain).

Finally, inductive analysis of the data showed that change-implicative talk about the existence and aspects of the patient’s physical pain (i.e., explicit and implicit referrals to change or lack of change) was pervasive throughout the question data. Implicit enquiries were more common than explicit enquiries. Several features of the physicians’ questions referred implicitly to changes in the patient’s experiences of pain (e.g., a time element such as “now”; various grammar devices and lexical choices). The physicians’ questions and the patient’s answers were more likely to be explicit when talking about lack of change and implicit when talking about change in the patient’s pain. The patient’s answers regarding changes in his pain tended to highlight changes for the better and lack of change, and minimize changes for the worse. The patient’s answers might be characterized for the most part as displaying troubles resistance (see Jefferson, 1988). The finding that change-implicative talk was pervasive throughout the question and answer data (a) shows the variable nature of pain in this palliative care context, that is, that pain in this medical context is anticipated to change, and usually not for the better; and (b) has implications for optimal health outcomes for palliative patients. (This point is discussed in more detail later in the section on optimization).
Medical Question Design and the Patient’s Answers

The next two questions I sought to answer were: How are the physicians' questions designed? What types of answers are occasioned by the physicians’ questions?

**Questioning turns and types.** I found that the physicians used both single- and multi-unit questioning turns and an assortment of question types. Specifically, physicians’ questions in the single-unit turns were analyzed. The distribution of the questions was as follows: 17 YNIs (38.6%), 15 YNDs (34.1%), 9 WH-Q (20.5%) and 3 ALT-Q (6.8%). There were seven multi-unit questioning turns. The type of questions in the multi-unit questioning turns was: YNI (4), YND (2), ALT-Q (2) and WH-Q (1).

These findings show that the physicians followed the recommended practice of using a diverse assessment style in this palliative care context (see Wilkinson, 2003/2011).

A main finding was that the physicians enacted the recommended practice of checking the accuracy of their understanding of the information provided by the patient (see Lussier & Richard, 2004; Sparks et al., 2007) via various strategies. Specifically, they used: (a) ALT-Qs to clarify information provided by the patient, (b) single-unit turn YNDs as gist formulations that summarized the patient’s previous talk, and (c) multi-unit turns with one question to summarize previous talk and seek confirmation/affirmation for the interpretation. Of special interest is the use of the multi-unit questioning turns. These turns were designed to act as benchmarks for the discussion and they occurred exclusively in Phase 2 of the physician-patient consultation (i.e., first part of the resident-patient consultation). This suggests the possibility that the residents were using these types of turns as a way of verifying that they had accurate information about the patient

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80 Assessing pain in a diverse fashion also was a recommendation of the supervising physician at the Clinic during the feedback sessions with the medical residents.
before the midway feedback session with the supervising physician. However, it is possible that multi-unit turns are a special feature of palliative consultations. That is, the extended time frame of palliative consultations (i.e., one to two hours versus 10 to 15 minutes for acute primary care medical visits) may construct a unique context in which physicians have the time necessary to use this type of benchmark turn to verify information. It also is possible that multi-unit turns are a feature of providing patient-centred care in the palliative context. That is, making an effort to verify the information provided by palliative patients closely aligns with the premise of providing individualized care that focuses on patients’ goals, values and concerns and that respects and is responsive to patients’ wants, needs, and preferences. The gist formulation and clarification questions (in the single- and multi-unit turns) furnished the patient with opportunities to give additional information, clarify and/or adjust the physicians’ interpretation of previously provided information, and discuss multiple (un)related issues.

The non-linear, doubling-back verification process displayed by the physicians in the present study is different from the linear trajectory of acute primary care consultations described in the CA medical literature. That is, in acute primary care, the physician ascertains the patient’s presenting concerns, performs an assessment of the patient’s condition, determines a diagnosis, and recommends or prescribes treatment (see Heritage & Maynard, 2006; Robinson, 2006). The doubling-back verification process in the present study is more time-consuming than a linear trajectory, but it suggests that these physicians are considerate of the patient’s tenuous status. That is, it is time-consuming and tiring for patients to prepare for consultations, travel to the Clinic, and partake in the activities involved in the lengthy medical consultations. If information is misinterpreted
by the physician and/or the patient did not have enough time to discuss all of his
concerns, it would be even more time-consuming and tiring for the patient to go back to
the Clinic several times over a short period of time to address what could have been
handled at the biweekly or monthly consultations. Research has shown that when
palliative patients perceive that they have not had adequate time to discuss their concerns
and issues they are dissatisfied with the palliative care services (e.g., Barclay et al., 2007;
Thorne et al., 2005) and they are more likely to experience increased emotional and
psychosocial distress (e.g., Desharnais et al., 2007).

**Question design and answers/responses.** Analysis of the questions employed
the same four dimensions of question design (i.e., topic and action agenda,
presuppositions, preference and epistemic stance) described in the CA medical literature
(see Boyd & Heritage, 2006; Heritage, 2010). Above I discussed the implications of
using questions designed for a no-pain answer; however, I note that in most cases the
topic agenda of the physicians’ questions presumed pain\(^{90}\) and involved at least one
aspect of pain. This finding shows that aspects of pain were a fundamental part of the
topic agenda of the assessment of pain questions. That is, to fully understand the patient’s
experiences of pain the physicians needed to formulate the topic of their questions to
encompass the complex nature of pain. In most cases, the patient conformed to the topic
agenda. The patient’s rejection of the topic agenda indicated that he viewed something
problematic about the topic. An interesting finding was that the patient rejected the topic
agenda of all of the questions that required him to evaluate the pain management care he
received from the physicians. This finding is consistent with previously noted research
that found that palliative care patients are often reluctant to evaluate their care (see
\[^{90}\text{As per the instructions of the supervising physician.}\]

\[244\]
Shillings et al., 2003), although in this instance, only one aspect of care is an issue (i.e., pain management rather than care in total).

Analysis of the action agenda of the physicians’ questions shows that they relied heavily on yes/no-type polar questions (almost 72% of the questions). As stated in Chapter 1, much of the palliative care literature on asking patients questions recommends that physicians avoid using closed-ended questions that restrict the range of possible answers (e.g., Sparks et al., 2007; Wilkinson, 2003/2011). A shortcoming of this recommendation is that it does not consider that closed-ended polar questions can be suitable and informative when used for certain purposes. For example, these types of questions can aid in the progressivity of the talk during physical examinations when physicians need to quickly collect specifics about patients’ situations. Asking concise and often truncated closed-ended questions allows physicians to progress efficiently through a checklist of standardized questions (see Stivers & Heritage, 2001). In most cases the patient in the present study conformed to the action agenda of the questions (i.e., provided the type-conforming answer). Also the patient demonstrated his orientation to the routine checklist objective via answering those types of questions with concise, type-conforming answers. This finding speaks to the patient’s familiarity with the medical environment and the requirements placed on him via the design of the physicians’ questions. Given the lengthy duration of his illness\(^91\) and his familiarity with the palliative care service\(^92\), it is understandable that he would be accustomed to the questioning routine.

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\(^91\) The patient had consulted with several different healthcare professionals about his disease for more than two years prior to his referral to the Clinic.

\(^92\) The patient in the present study was a patient of the supervising physician prior to the Clinic opening and he attended regular visits at the Clinic for the year that the data were collected for this project.
The most common presupposition inherent in the physicians’ questions was that the patient had pain (e.g., a question about the severity of pain presupposes that the patient has pain). Other common presuppositions were that the patient (a) was able and willing to describe his pain (via the aspects of pain such as severity, frequency, site, etc.); (b) was taking medication to control his pain (management/control); (c) had at least some control over his pain (management/control and effects of treatment); (d) might be willing to take more medication (management/control); and (e) was willing to evaluate his satisfaction with the pain management plan developed by the physicians (management/control). The majority of the questions had at least two presuppositions and as many as four. As with the topic agenda, the presuppositions often involved one or more aspects of pain.

The finding that the patient’s type-conforming answers were delayed and/or deferred the majority of the time (71%) indicates that he possibly viewed something problematic about one or more of the presuppositions in the physicians’ questions. However, the patient’s delay in answering may in part be due to fatigue related to being a palliative patient. During Phase 1 of the present study the supervising physician explained to the residents that palliative patients often take longer to answer questions because they are usually experiencing severe pain and/or fatigue during their consultation. The supervising physician advised the residents to afford patients extra time to answer questions and explain their situations before asking another question or making an assertion or assessment.

93 The supervising physician did not comment on any cognitive limitations or problems in understanding that may have contributed to the patient’s delays in answering questions. In any case, it is not possible in this sort of study to determine the influence of such factors.
On several occasions the patient displayed that he did not accept one or more of the presuppositions via non-type-conforming answers, non-committal answers, replacement transformations or partial-modified repeats. The patient’s rejection of the presuppositions occurred most often to questions that presupposed (a) a negative progression of his disease, or (b) that he was willing and/or able to evaluate his care. This finding supports my earlier comments about the patient displaying a stoic stance and his seeming discomfort with explicitly evaluating the care he received from the Clinic.

A main finding regarding preference was that 73% of the YNIs preferred a no-type answer because of the inclusion of a negative polarity item (e.g., any, ever, not, or no). The polarity of YNIs has implications for the elaboration of answers. Specifically, positively polarized YNIs encourage elaboration and negatively polarized questions discourage elaboration. Elaboration is an important component of the physicians’ assessment of patients’ physical pain. The significance of elaboration warrants its own separate treatment and it is considered in more detail later in the Discussion. The patient provided type-conforming answers to the majority of the physicians’ questions. The patient gave dispreferred answers/responses and/or went beyond the limitations of the requirements of the questions (i.e., provided expanded answers) most frequently to reject the implication that his pain was worse and/or his disease was progressing, and when the question required him to evaluate the pain management plan. This finding also demonstrates the patient’s stoic stance and his seeming discomfort with explicitly evaluating the care he received from the Clinic.

By virtue of asking a question, the physicians demonstrated a K-epistemic stance; however, the type of question had implications for the degree of K-epistemic stance (i.e.,
YNIs display more K- epistemic stance than YNDs; see Heritage, 2010). The finding that the physicians asked slightly more YNIs than YNDs tells us that the physicians generally viewed the patient as more knowledgeable (i.e., relatively greater K+ epistemic stance) about his experiences of pain than themselves. In some instances, the patient pushed back on the restrictions placed on his answer, thereby claiming greater K+ epistemic stance and social entitlement over the topic of the question. For example, the patient claimed greater K+ epistemic stance and social entitlement over the relevant information about his experience of pain via approaches such as: (a) repeating part of the physician’s question at the beginning of his answer; (b) providing non-type-conforming, dispreferred, expanded answers to YNDs and ALT-Qs; and (c) performing a self-initiated, self-repair that rejected the physician’s use of a minimizer (“just”) that downgraded his experience of pain (see Heritage & Raymond, in press).

Raymond and Heritage (2006) discuss the struggle that can occur when a speaker works to “both manage her (or his) independent access to the matters being assessed and avoid intervening too far into the ‘territorial preserves’…territories of feelings, knowledge, and ownership” (Raymond & Heritage, 2006, p. 700) that the recipient defends as her or his own. The recipient defending her or his status works to monitor “the boundaries of knowledge to which she (or he) can claim special rights by virtue of her (or his) status” (Raymond & Heritage, 2006, p. 700) as the one who has experienced the topic of the talk. In the present study, the physicians had to both manage their independent access to the probable experiences of pain of someone in the patient’s position (assessed via medical knowledge and observations of the patient’s bodily movements) and avoid intervening too much into the “territorial preserves” (Raymond &
Heritage, 2006, p. 700) of the patient (e.g., this is evident in their use of evidentials such as \textit{it sounds like}). Meanwhile, the patient worked to monitor the boundaries of the knowledge of his experiences of pain to which he could claim special rights by virtue of his status as the one living with the pain. The patient’s claims, which index a greater K+ epistemic stance over the talk about his experiences of pain speak to palliative patients’ need to be heard as “a person experiencing an illness, rather than a patient in some stage of disease progression” (Kuhl, 2002, p. xxi) who has little control over what is being done to his or her body by the disease. Claiming social entitlement or ownership over the talk regarding their physical experiences might be one of the few instances in which palliative patients have any control over their experiences.

**Principles of optimization and problem attentiveness.** According to Boyd and Heritage (2006; see also Heritage, 2010), optimization is displayed when physicians’ questions are designed so that the preferred answer confirms a best case or optimized health outcome, which in most medical contexts is the improvement or cure of a patient’s medical issue. The principle of optimization in the palliative care context in the present study was displayed when the physicians’ questions were designed so that the preferred answer confirmed the optimal health outcome that the patient’s pain was stable (i.e., made relevant answers that indicated no change in pain, no new pain, or managed pain). A total of 24 of the 38 physicians’ polar question were optimized. Sixteen of the 24 questions displayed the principle of optimization consistent with the patient’s pain being stable. The patient accepted the optimized design for ten of these questions. For the other eight (of the 24) optimized polar questions, the optimal health outcome was no pain. The patient clearly rejected the optimized design for two questions; he accepted the optimized
design for six but displayed (e.g., through qualifications, delays) that there was something problematic about these questions.

The optimized design of the four no-pain questions asked during the physical examination is not unexpected given that such examinations are usually accompanied by a set of standardized enquires that includes such questions (i.e., the routine checklist) (see Stivers & Heritage, 2001). The patient’s type-conforming answers that indicated no pain likely show the patient’s orientation to the routine checklist objective; delays in his responding (0.5 to 0.7 seconds) indicate some form of problem, but the exact nature of the problem is difficult to determine. As previously stated, the supervising physician informed the residents that palliative patients can take time to answer questions; this could be what is occurring with these four answers. However, the patient usually provided preferred answers with no delay to the questions that indicated a stable optimal health outcome (i.e., no change or no significant change in his experience of pain); thus, it is possible that the delays in answering are displaying a disalignment with the no-pain optimal health outcome. That is, although the patient aligned with questions that indicated no change in his condition, the delays indicate that he did not deny having pain or changes in pain. This was also evident in his dispreferred answers to no-pain questions in which he reported details of his pain. Findings from my study may indicate that in a palliative context in which patients have comorbidity and declining health, the optimal outcome for routine checklist questioning (as discussed by Stivers & Heritage, 2001) needs some consideration. The patient’s medical condition (e.g., placement of known tumours, metastasized cancer) may suggest an optimal outcome for routine checklist questions that is different from that for acute and primary care consultations.
The principle of problem attentiveness is displayed when a physician designs questions that are broadly in line with a symptom previously mentioned by a patient and that presupposes there is a problem (see Stivers, 2007). Fourteen of the physicians’ 38 polar questions, 8/9 of the WH-Qs and 4/4 of the ALT-Qs displayed the principle of problem attentiveness. The physicians placed most of the problem-attentive questions midway or later in the consultations. This finding tells us that even though the physicians were informed of the patient’s report of pain on the ESAS, they usually conducted the first part of the consultations with the assumption that the patient’s pain was not immediately problematic. As previously stated, the ambiguity surrounding physicians’ and patients’ interpretations of the numeric values on the ESAS and the Clinic’s mandate that assumes patients’ pain, would warrant initial questions that assume the patient’s pain is (or at least may be) problematic. The patient provided type-conforming, preferred answers to most of the problem-attentive questions and he usually offered some details about his pain. This finding tells us that the patient oriented to the nature of the problem-attentive questions.

**Progressivity and cohesiveness.** The physicians’ questions frequently included lexical devices that connected them to the prior talk (e.g., gist formulations; prefaces to the question such as and or so; evidential phrases such as it sounds like). This finding shows how cohesiveness and progressivity of the talk in the consultations was enacted. That is, the physicians’ turns constructed a sense of fluidity to the consultations by sequentially building on previous talk; thus the consultations appeared more like discussions rather than investigations of the patient’s condition. However, on several occasions the progressivity of the talk was disrupted when the patient did not answer or
even respond to the physicians’ questions. In these cases, the questions appeared to be
difficult to answer because they (a) contained inapposite terms, (b) were designed poorly,
(c) made relevant an evaluation that appeared depreciatory in some sense, or (d) were
part of a double-question multi-unit turn.

The medical literature recommends that physicians speak in lay terms, that is, talk
without medical jargon (e.g., Heyland et al., 2005; Ptacek & Ptacek, 2001). An
interesting finding in the present study was that the patients’ confusion about terms in the
physicians’ talk was not limited to medical jargon. That is, inapposite terms such as
“happy” and “relief” in the context of talk about pain medication appeared equally as
problematic for the patient as the medical terms. In both of these situations, when the
patient displayed trouble producing an answer, the physician asked a follow-up question
that rephrased the initial question in a manner that explained the inapposite word. Thus,
the physician held herself accountable for initially asking about the patient’s pain with an
inapposite term. It also is recommended in the literature that physicians phrase their
questions in a manner that makes it easy for patients to answer. That is, physicians’
questions need to be designed so that patients can determine what is being asked. For
example, in the present study the question “What is the pain?” is a difficult question to
answer because it is poorly designed and “what” is an inapposite term in the context of
this sentence. Also, questions need to be designed so that the answer does not appear to
depreciate the patient in some respect. For example, in a multi-unit turn the physician
asked the patient “In FACT You ranked it as:: a little even bit better than the last time ar-
around, >do you think that that’s the truth?, < or somewhere (hh)huh probably about the
same.” Either answer option in this ALT-Q would result in a self-depreciatory answer: if
he says that his answer on the ESAS is the truth then it implies that he lied in his earlier verbal report to the physician, and if he says that his pain is about the same then it implies that he lied\textsuperscript{94} on his ESAS form. Either way his answer portrays him as unreliable.

**Patterns of Elaboration and Exceptions to the Consistent Patterns of Elaboration**

The last two questions I sought to answer were: How do the physicians’ questions encourage or discourage elaboration? Do the patient’s answers conform to or deviate from the requirements of the question?

As previously noted, preference and the optimized or problem-attentive design of questions have implications for whether or not the patient is encouraged to elaborate on answers. A main finding was that 30% of the questions were designed to encourage elaboration. The questions that encouraged elaboration were positively polarized YNIs designed to display problem attentiveness, and *what* and *how* questions. The patient provided elaborated answers to 50% of these questions. The patient provided the most detail in response to the *how* questions that were non-specific with regard to the aspects of pain and that were asked near the beginning of the consultation (i.e., shortly after the opening pleasantries; at the beginning of the presenting concerns). This suggests that when the patient is afforded the opportunity to give the details about his experience of pain that are most salient to him near the beginning of the consultation, he is likely to provide descriptive answers.

Answers/responses contrary to the expected elaborated answers could be understood in terms of question design problems (e.g., grammatically malformed questions), content issues (e.g., requiring the patient to evaluate the physicians’ pain

\textsuperscript{94} The suggestion that this question implies that the patient has lied is a strong statement; however, the physician’s use of the term “truth” (in contrast to “correct”) does invoke the notion of lying (versus being mistaken), and it is another example of the problem of inapposite terms in questions.
management plan), and the problem of double-question turns. The questions that discouraged elaboration were YNIs that were optimized and/or contained negative polarity items, YNDs, ALT-Qs, and *when* and *where* questions. The patient provided elaborated answers to 40% of the questions that discouraged elaboration.

Answers/responses contrary to the expected non-elaborated answers could be understood in terms of dispreferred answers, question design problems (i.e., ALT-Qs presented as two questions rather than as one continuous question) and content issues (i.e., inapposite terms, ambiguous topics and/or dismissive or inaccurate content).

The patient’s elaborated answers informed the physicians (a) about increases in his physical pain relevant to effects of treatments (i.e., chemotherapy and radiation); (b) about decreases in pain when questions implied disease progression; (c) that he was not receptive to offers of more medication; and (d) that he was uncomfortable evaluating the pain management services he has received from the Clinic.

**Open- versus closed-ended questions.** As noted in Chapter 1, the practiced-based literature relevant to physician-patient interactions in palliative care recommends that physicians use more open-ended questions to allow patients to express their concerns (e.g., Lussier & Richard, 2004; Sparks et al., 2007; Wilkinson, 2003/2011). This literature constructs a dichotomous situation wherein *yes/no* questions are advised against and *wh*-questions are recommended. As previously noted, this simple dichotomy can be problematic when put into practice. For example, Robinson’s (2006) research (described in Chapter 1) shows that not all *how* questions occasion elaborated answers; the type of answer the patient provides largely depends on the sequential placement of the question. Further, it has been argued that “not all *wh*-questions are equally open” (Heritage, 2002,
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

p. 68) with regard to encouraging elaborated answers (Fox and Thompson, 2010; Heritage, 2002). That is, what, why and how questions encourage a telling (reports, stories, accounts, etc.) and are viewed as more open than who, when and where questions, which seek specific pieces of information and which the patient is encouraged to answer in a concise manner with little elaboration (see Chapter 5 for more details). It has also been argued that some polar questions are more open than others in that they encourage more elaboration or sequence expansion (see Heritage, 2010; Raymond, 2010). Specifically, the CA literature suggests that polar questions have different degrees of openness, with YNIs being more open than YNDs and ALT-Qs. However, the openness of YNIs is restricted with the inclusion of a negative polarity item (e.g., any, not, ever, at all) and/or the preference for an optimized outcome (Heritage, 2010). Negatively polarized and/or optimized YNIs are designed to make relevant the same kind of type-conforming, minimal answers as YNDs.

The degree of openness of a question is not based only on question design; the content of the question has implications for the amount of elaboration the question encourages. For example, as previously noted, the principle of optimization is displayed when a physician’s questions are designed so that the preferred answer confirms an optimal health outcome (see Boyd & Heritage, 2006; Heritage, 2010). This principle cannot be displayed unless the design of the question and the content of the question (i.e., best case or optimized health outcome) are aligned. Content also is relevant to questions that display the principle of problem attentiveness (Stivers, 2007). This principle is displayed when a physician designs questions that are broadly in line with a symptom previously mentioned by a patient and that presupposes there is a problem.
In the present study, during the briefing between the supervising physician and each resident (Phase 1), the residents were instructed by their supervisor to learn as much as possible from the patient about his current condition. The finding that the majority of the physicians’ questions were designed to discourage elaboration appears to be directly contrary to the supervising physician’s instructions. However, closer examination of the context in which the questions were located and the content of the questions indicated that some of the questions that discouraged elaboration were appropriate. For example, in the context of the routine checklist objective (enacted during physical examinations) questions about specific pain that discouraged elaboration aided in the progressivity of the talk. In this instance, the patient provided the sought-after information with his non-elaborated, type conforming preferred answers and analysis of the subsequent talk indicated that the physicians displayed satisfaction with his answers. However, the physical examination was only a small portion of each consultation. In the palliative care literature, the process of pain assessment is described as going beyond simply obtaining descriptions of pain to learning about the details of the patient’s experiences of pain as a means of evaluating the subtleties of disease progression. Learning details about the patient’s experiences of pain requires asking questions that encourage elaboration of simple answers.

**Additional Findings: Troubles Resistance**

The patient displayed troubles resistance (see Jefferson, 1988) via the following discursive actions: he (a) either stated his wish to avoid more medication or gave non-committal answers to questions that implied a possible medication change; (b) gave non-committal, hedged or downgraded answers to questions that implied disease progression;
and (c) highlighted changes for the better and lack of change, and minimized changes for the worse. That is, he played down the pain’s effects on his body and day-to-day life (see Gill & Maynard, 2006), hedged his disclosure of pain to display a stoic stance (see Heritage & Maynard, 2006) and demonstrated that he was coping with his pain with fortitude (see Heritage & Robinson, 2006a). In contrast, the patient displayed troubles telling when asked about his experiences of pain in relation to chemotherapy and radiation treatments. That is, he (a) gave explicit claims of the effectiveness of these treatments; and (b) reported pain associated with these treatments, stipulating that the pain experienced was temporary during the treatments and that the pain returned to previous levels or diminished after the course of treatments.

The patient’s displays of troubles resistance and conditional troubles telling was consistent with his explicit talk about his (a) refusal to accept that he is going to die in the near future (e.g., “Yeah cause (patient’s name) is not planning ta die you know” [Consultation 3]; “I'm not planning to die ah within you know fifty years.” [Consultation 3]); and (b) belief that his cancer can be cured at some point in the future (e.g., “Right now there is no cure maybe usually. But who knows what happens tomorrow. They can invent something and that's it. Cancer is not a problem. It could be as oh but when it happens I'm trying not to die before this” [Consultation 5]). Faced with the certainty of death, but the uncertainty of when that death will occur, palliative patients may express “hope and optimism as resources for dealing with and attempting to ease the burdens arising from the often harsh and restrictive impositions” of such a prognosis (Beach, 2002, p. 189). Physicians can experience difficulty in communicating with overly optimistic palliative patients whom they may see as in denial. In the next section I will
discuss the ways in which my main findings are relevant to the physicians’ talk during the feedback sessions that construct the interactions with the patient as being “difficult.”

“Difficult” Consultations

During the feedback sessions between the supervising physician (SP) and three of the medical residents, the physicians constructed the consultations with the patient as “difficult” in two ways: (a) it was difficult to obtain information from him, and (b) it was difficult to respond to his perceived state of denial of the prognosis. The SP asked each resident during the feedback session, “So how did you find that interview went for you?” Three of the five residents reported that they found it “difficult” to interview the patient.95 In addition to describing the consultations as “difficult”, the residents reported that: “he wasn’t very forthcoming with me…mostly they (his answers) were one word (R1); “(he was) a bit more reserved than was expected” (R2); “I mean he answered all my questions and he wasn’t giving me I didn’t feel he was giving me any attitude per se but I just felt like he was a little bit…it was really hard to get a rapport with him…I dunno what it was. But trying to get going with him I felt like it was ha- it was harder” (R3).

SP’s responses aligned and affiliated with the complaints of two of the residents’: “he’s a hard person to interview” (SP; Consultation 1); “He’s not the easiest person to sort of establish a connection with um he can be sort of very yes noish in his answers. But still he’s not an easy fellow to interview…the way he responds it’s almost like a yes no or a very sort of fairly succinct answer” (SP; Consultation 3). Further, four of the five residents described a “feeling” that the patient was not providing as much pain

95 The scope of my study did not afford me the opportunity to do a systematic analysis examining the differences between question-answer adjacency pairs in ‘difficult’ and ‘not difficult’ consultations or between pain questions and other types of questions (e.g., lifestyle questions, social support questions). This is an area of interest for future research.
experience information as he could have; that is, he was providing them with answers but the answers were not very informative.

Although the physicians’ comments seemed to some extent to attribute the patient’s lack of information disclosure to something inherent in him (e.g., “Um partly his characteristics”; R1), SP and the three residents who described the interaction as “difficult” admitted that their assessment style may have, in part, contributed to the limited amount of detailed information they obtained from the patient (“Um partly his characteristics partly things I'm sure that I was doing as well”; R1). Findings from the present study provide support for the presumption that the limited amount of detail provided by the patient was largely due to the types and design of the questions and the content or topic of the question. That is, 70% of the physicians’ questions made relevant a yes or no-type answer and discouraged elaboration. Further, just half of the questions that encouraged elaboration received it because of question design problems, the inclusion of inapposite terms, and topics the patient displayed a hesitance to address.

The resident’s complaint that it was difficult to “get going” (R3) with the patient was likely occasioned by the lengthy pauses before many of his answers/responses and his hedged, non-committal answers. The findings show that when the physicians asked the patient a well-designed question, he produced an immediate, type-conforming answer. However, when the questions had design and/or content issues the patient paused for lengthy periods of time, and often produced perturbations (e.g., “Um”, “Ah:”) that allowed him to occupy the turn space until he produced an answer or a response. This process impeded the pain assessment process and the progressivity of the talk. On some occasions the patient provided transformative responses that altered the agenda of the
question to something that he was capable of answering. Also, he provided expanded answers and dispreferred responses that disclosed more information about his condition to the physicians.

However, the physicians were partly correct in that on some occasions the patient was not forthcoming with sought-after information. That is, my findings show that the patient displayed troubles resistance to questions regarding pain medication increases/changes and possible signs of disease progression. This finding speaks to the physicians’ second complaint that the consultations were difficult when the patient displayed a “kind of reluctance to continue on with pain medications” (R2) and he appeared to be “fighting” or “denying” possible signs of disease progression (R2). However, SP suggested that the patient’s displays of resistance were understandable given his situation: “I think the whole concept of pain is equal to disease progression. He’s hoping that pain it means that the chemo is killing his tumour” (Consultation 2). Further, she explained that it is part of their job as physicians to help patients to accept their situation and to be sensitive to the fact that it may take some patients longer than others to come to this acceptance. The following excerpt exemplifies these points:  

Example 2 (Consultation 5):

SP: Um did you notice what I was trying to do with the chemotherapy when I had that part of the discussion, that okay so you've tried one you're feeling positive and what I tried to do is that you're hoping for and I don't remember how the exact words go that you know this will give you time. And what I tried to subliminally implicate is that um this is not gonna be forever and ever.

R: Uh hm. He seemed to take that and say this will give me time to live until they do find a cure. Or that's seems to be his thought.

SP: Yeah. And for the time being I don't want to really work on breaking down his defenses because he's coping as he's coping. He doesn't have a social network. In fact very minimal.

As previously noted in Chapter 3, excerpts of talk from the feedback sessions between the supervising physician and the residents are used as background information when interpreting the results of this study, not as part of the analyses.
SP: And I-I see him as quite a linear ah thinker.
R: Uh huh.
SP: And you know there's a task at hand. His task is to live and to do well with chemo. He's gonna put up with the side effects and you know take care of his son and that's where he's at.

Also, the physicians talked about the importance of helping the patient to set realistic goals and to have quality of the life for the time he has remaining. Example 3 shows one such conversation:

Example 3 (Consultation 4):
SP: Okay. What I thought you really did well is that you were trying to start to move the patient towards okay you have this hopes of the cure but how do we set realistic goals?
R: Uh hm.
SP: He's still not ready to go there.
R: Uh hm.
SP: Um pt so and most residents aren't able to sort of start going to that place but he is deteriorating and I have the benefit of seeing him over time. But at what point do you start saying okay we hope for the best but start preparing for the worst.
R: Uh hm.
SP: And I think what you were able to do is start to introduce that concept and with each visit hopefully um start to get him instead of looking into the future what is your hope for the next day? For the next week?
R: Uh hm. Create goals realistic [goals]
SP: [Yeah ]
R: for the short time for the
SP: Yeah.
R: near future.

According to Beach (2002), managing optimism requires recognizing “how personal coping with cancer involves an inseparable relationship between hope and restricted choices” (Beach, 2002, p. 189). Although the physicians complained about the patient’s reluctance to provide information and the difficulty they experienced responding to his displays of “denial”, they acknowledged that he is in a challenging situation. It is difficult for both the patient and the physicians to find an effective method of talking
about the process of dying. However, if the physicians consider the type of information
that they require from the patient and they then design their questions to make relevant
answers that fit their requirements, it is likely that they will be able to address at least
some of their complaint about the patient’s apparent reluctance to provide information.

Comparison of Findings with Other CA Medical Research

In the present study, multi-unit turns were usually used by the physicians to
summarize or clarify information previously provided by the patient before enquiry of the
next topic. Currently, I am not able to ascertain if multi-unit questioning turns are used in
medical contexts as there is no published CA research that explores this topic. It is
possible that, given that the majority of the published CA medical research examined data
collected in acute primary care (in which the length of consultations was significantly
less), multi-unit questioning turns are unique to palliative care contexts due to the longer
period of time afforded these consultations. Exploration of the use of multi-unit
questioning turns across medical contexts has the potential to increase our knowledge
about the ways in which assessments of symptoms such as pain are being performed.

Detailed analysis of the questions showed that the physicians’ asked five general
kinds of questions: new concern questions (11 times); questions designed to evaluate the
patient’s level of satisfaction with the pain management plan (10 times); questions about
change or lack of change in P’s experience of physical pain (7 times); gist formulations
that summarized previous talk (7 times); and questions that asked for clarification of
previous talk (9 times). An interesting feature relevant to the first three kinds of questions
is that they map onto the three types of reasons for visiting the doctor identified by
According to Robinson, “each of these different reasons make relevant different types of medical goals and activities, and thus different interactional trajectories, for visits” (Robinson, 2006, p. 23).

According to Robinson (2006), primary care medical visits usually have only one purpose for the visit. In contrast, the present data showed that each palliative care visit included all three reasons. First, the physicians asked at least one question in each visit relevant to new pain. However, in contrast to Robinson’s (2006) data in which the physicians designed their questions to make relevant an answer about the presence of a new concern, the palliative care physicians designed most of their yes/no new concern questions to prefer an answer that indicated no new pain. The one YNI that preferred an answer indicating the existence of pain was designed to be problem attentive and was asked after the patient informed the physician about an experience of pain. This finding demonstrates an important difference between primary care visits and palliative care consultations. That is, in primary care it is expected that the patient will present a new concern if that is the purpose of the visit, whereas in palliative care, the physician assesses whether the patient has a new pain before pursuing information about a new concern.

Second, each physician asked at least one question that enquired about the patient’s level of satisfaction with the pain management plan. These types of questions are similar to questions asked during “follow-up visits” (Robinson, 2006, p. 24). That is, these questions (a) “display the physicians’ knowledge of a particular concern” (Robinson, 2006, p. 29) i.e., physical pain; (b) solicit an assessment of the effectiveness of the course of action that was taken in the previous consultation; and (c) “communicate
physicians’ understandings that patients have follow-up (vs. new or routine) concerns” (Robinson, 2006, p. 29). Third, each physician asked at least one question about change or lack of change in the patient’s experience of physical pain. These types of questions are similar to questions asked during “chronic-routine visits” (Robinson, 2006, p. 36) in that they are “designed to communicate physicians’ understandings that patients are visiting to deal with chronic-routine concerns” (Robinson, 2006, p. 36).

The finding that the palliative care consults incorporated all three reasons for medical visits shows the unique nature of these types of visits in comparison to those in other medical contexts. This is likely due in large part to the extended time frame for the palliative visits, but it also speaks to this unique specialization of care. That is, physicians in the palliative context have a complex job in that they need to (a) monitor the appearance (or not) of new concerns that could indicate disease progression, (b) check on the effectiveness of recommendations from the previous visit, and (c) keep track of chronic health issues to determine if there have been changes that need to be addressed (e.g., in addition to the primary diagnosis, many palliative patients have multiple health problems and often extensive co-morbidity related to their decline in health).

Future CA medical research on the design of physicians’ questions in relation to patients’ answers may need to give additional consideration to content. As previously noted, CA research has talked about the relevance of content to question design in a number of different ways (e.g., principles of optimization and problem attentiveness, question presuppositions and topic agenda, and assessments). My research adds some specific content issues to the existing CA medical research, and CA research in general, that have not been discussed. Specifically, my research contributes to the current CA
medical literature regarding what counts as an optimal outcome in a medical context. That is, other medical contexts take a curative approach and the topic of optimized questions reflects this practice. Palliative care is unique in that a patient’s health is expected to deteriorate and an optimal outcome is framed as the patient’s health status remaining stable. As previously stated the content and design of the patient’s answers to no-pain questions, both within and outside of the routine checklist objective, warrant consideration in relation to the ways in which the principles of optimization and problem attentiveness are discussed. That is, in the palliative context it appears that what counts as an optimal outcome or a problem is not as clearly defined as it may be in other contexts such as acute and primary care. A palliative patient’s physical condition is an ongoing problem that does not have an option of improving as is the case with patients who do not have life-limiting illnesses.

Another specific content issue identified in my research is that question content relevant to disease progression can occasion answers/responses that deviate from that which is made relevant by question design alone (e.g., the patient may provide elaboration when the question design does not encourage it as a means of rejecting this implication). Some of the physicians’ questions implied disease progression, rather than explicitly enquiring about it; that is, disease progression is one aspect of the content of presuppositions rather than the topic of a question. Related to questions that imply disease progression are questions about taking more pain medication. The content of questions about pain medication can be particularly challenging for certain types of palliative patients. For example, the content of inherent presuppositions in questions related to taking pain medication may imply the physician’s willingness to prescribe
more pain medication. A stoic patient may reject the presuppositions by giving a
transformative answer that addresses the implication of a medication change (e.g., denial
that the pain has changed or that more medication is needed to address the pain); the
patient thus appears less willing than the physician to consider a medication change. The
content issue of prescribing medication also is relevant to other medical interactions but it
may play out differently than it does in palliative care. For example, Stivers’ (2007) CA
medical research examined physicians’ presuppositions that parents were more willing to
receive antibiotics for their child’s illness presentations than the physicians were willing
to prescribe. In these instances, the physicians designed their talk regarding medication
prescriptions to discourage parents’ subtle requests for antibiotics.

Question content relevant to evaluation of services is a more general CA content
issue (i.e., evaluation of services relates to many interactional contexts). However, as
previously noted, in a palliative context physicians’ questions relevant to satisfaction with
services can occasion answers/responses that deviate from that which is made relevant by
question design because palliative patients may be particularly reluctant to criticise their
care (Shillings et al., 2003). My analysis of palliative care interactions suggests
consideration of this medical context in relation to question design and content also is
worthy of further attention.

Finally, my finding that the majority of the physicians’ questions limited the
patient’s answers because the questions were optimized, made relevant simple yes- or no-
type answers and discouraged elaboration is consistent with Rogers and Todd’s (2000)
finding of “information-limiting strategies” (p. 303) in oncologists talk with cancer
patients about their pain. My finding that the patient’s answers minimized his pain (e.g., “may be a bit more painful”) is consistent with Rogers and Todd’s (2010) finding in their research about cancer patients’ talk about their pain. Although my findings were consistent with Rogers and Todd’s (2000; 2010) research, these authors did not take full advantage of the CA methodology; thus my findings provide more detail.

**Limitations**

**Limitations of Participant Sample**

One limitation of the study sample is that five of the six physicians were medical residents doing a palliative care rotation, rather than experienced palliative care physicians. Given that the residents were learning how to provide palliative care services, my findings may not reflect the practices of experienced palliative care physicians. I do not know whether I would obtain the same, similar or different results analyzing physician-patient interactions that involve experienced palliative care physicians. Consequently, I cannot claim my findings are specific to medical residents in this palliative care context nor can I generalize my findings to physicians of varying experience and/or in other palliative care contexts. However, my research identifies some practices (e.g., with respect to the design and content of questions) that medical residents, experienced palliative care physicians, and physicians in other medical contexts might find useful.

Another limitation of the sample was that I focused on five consultations with one patient. However, this qualitative research involved very fine-grained analyses from multiple angles, and even the small number of consultations generated a substantial

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97 This study is discussed in more detail in Chapter 1.
98 This study is discussed in more detail in Chapter 1.
amount of data. Sample size for this type of research refers to the number of bits of discourse rather than the number of participants (Wood & Kroger, 2000).

Finally, it can be argued that focusing on a patient whose first language is not English (i.e., in which English is his second language or ESL) is problematic with regard to meaning and interpretation of the findings. However, I believe that the patient demonstrated on numerous occasions his sophisticated working knowledge of English. For example, in the excerpt in which the resident confounded “feel pain” and “notice pain” the patient explicitly made the distinction and attempted to correct the resident. It could be argued that the patient is making an idiosyncratic distinction between the lexical categories of “feel” and “notice” that is related to his ESL standing; however, perhaps it is something more basic. That is, the patient’s talk about noticing is an action and feeling is a perception. The patient’s focus on the discursive rather than the cognitive act conveys to the physician that he has pain but he is not going to make this talk into an interactional matter (i.e., his pain is present or noticeable but it is not worthy of more discussion about his feeling regarding the pain). Other displays of misunderstanding were usually explainable by grammatical question design (e.g., malformed questions) and content issues (e.g., inapposite terms and pro-terms with no explicit referent). Finally, the patient is educated and he displayed his working knowledge of Spanish, as he conversed with one medical resident whose first language was Spanish, and he spoke some Italian and Latin with the supervising physician. Finally, sequential analysis of the data showed no signs of the physicians experiencing problems communicating with the patient specific to his linguistic abilities.
It should be noted that the geographical area where the Clinic is located is multicultural with a high percentage of the population of the area and the Clinic having English as their second language (ESL). Thus, physicians at the Clinic are accustomed to interacting with ESL patients. In any case, it is important to examine the ways in which these types of interactions play out, as this information is useful for these types of interactions and may well be helpful with other populations.

**Limitation of the Data Set and Analysis**

The present data set was incomplete in that not all of the consultations were video-taped; consequently, my analysis was not multi-modal (i.e., I could not examine the coordination of talk and embodied movements such as gesture, eye gaze, etc.). The implications of focusing on only the talk are that I was not able to determine: (a) what was happening during some periods of extended pauses; (b) what participants were referring to when they used some deictics, and (c) if the participants’ gestures and/or eye gaze provided clarification for some talk that was difficult to interpret. However, when the video was available, I did provide some multi-model analysis. Although this was not done consistently or in a comprehensive manner, it did add to my analysis and understanding of some of the interactions in the data set. Further, the use of next-turn proof procedures and analysis of the larger sequences of talk added significantly to my understanding of the data.

**Limitation of the Topic**

It can be argued that a limitation of the present study is that I treated talk about experiences of physical pain separately from talk about pain medication, emotional pain and psychological pain. Although these topics are not mutually exclusive, there was a
natural separation between them in the data set. I chose to focus on the talk about the patient’s experiences of physical pain as this constituted the largest sample of question and answer adjacency pairs. Talk about pain medication usually involved the physicians discussing medication dosage and side effects while the patient listened and few questions were asked. Talk about emotional and psychological pain was limited in the data and was not explicitly discussed as pain. Further, physicians have identified talk about experiences of physical pain as one of the most challenging aspects of medical practice, particularly in palliative care (L. E. Wood, MD, personal communication, April 2012).

Implications for Palliative Care Practice and Training

The present study shows the utility of CA in studying medical interactions and expands our understanding of types of talk in this context. That is, this study can inform palliative care physicians, general practitioners and medical residents doing a palliative rotation about how different types of questions regarding the complex topic of patients’ experiences of pain shape the type of information that is obtained. While I have discussed the issues raised in my study with a few physicians, explicit recommendations for practice and training need to be developed and implemented in conjunction with medical practitioners in a palliative context in order to ensure that recommendations consider both what is best for patients and what is practical for physicians. The following is a summary of findings from the present study that may be of particular interest to those working and doing research in palliative care contexts:

1. Research by Clemente et al. (2008) demonstrated that non-focused questions invite children to talk about the topic being enquired about and these questions
give the recipient latitude regarding what is discussed about the topic. Similarly, I found that non-specific how questions that presumed pain (e.g., “How is your pain?”) invited the patient to talk about the aspects of his pain that were most salient to him. However, there was a sequential factor to this finding. That is, non-specific how questions asked at the beginning of the consultation occasioned more detailed answers than when they were asked midway or later in the consultation. This is likely because at the beginning of the consultation there were several aspects of pain that the patient could address whereas later in the consultation the patient had already answered several questions about the aspects of his pain and the possible topics he could address were more limited.

2. My findings suggest that no-pain questions may be problematic depending on when they are asked. Asking open-ended non-specific questions such as “How is your pain?” and “Tell me about your pain?” outside of the medical examination invite the patient to report pain. During the medical examination (i.e., during the routine checklist questioning), recipient design would indicate that whether or not questions are optimized to indicate no pain or problem attentive to indicate pain depends on the medical condition of the patient.

3. Asking a wide variety of questions about numerous aspects of pain facilitates the assessment of the complex nature of patients’ experiences of pain, disease progression and the efficacy of the pain management plan. However, findings from the present study indicate that simplicity in question content is more likely to occasion answers that address the aspect of pain (i.e., enquire about one aspect
of pain per question) than questions that enquire about more than one aspect of pain.

4. I found that explicit requests for evaluations of patient satisfaction with services do not occasion useful feedback. As previously suggested, CA methodology may provide some useful ways of assessing patient satisfaction.

5. Some question designs more than others can encourage answers that provide the physician with details about the patient’s pain. As has been discussed in other CA research (e.g., Fox & Thompson, 2010; Heritage, 2002; Heritage, 2010; Raymond, 2010), YNI questions with positive polarity or that are problem attentive (“Is that a new pain?”) and how or what questions (“How is your pain after this last chemo session?”; “What does your pain feel like?”) encourage elaboration. I found that while some such questions did obtain elaborated answers, others did not. The questions that did not obtain elaboration were either malformed or involved ambiguous or delicate topics (e.g., evaluation of pain management).

6. Consistent with other CA research (e.g., Boyd & Heritage, 2006; Heritage, 2010; Stivers & Heritage, 2001) I found that gist formulations and clarification questions (in the single- and multi-unit turns) furnish the patient with opportunities to give additional information, clarify and/or adjust the physicians’ interpretation of previously provided information, and discuss multiple (un)related issues.

According to Stivers and Heritage (2001), although the preference structure of physicians’ questions puts constraints on patients’ answers, preference is not necessarily deterministic in that patients can break free from the constraints of the question to add information. In ordinary conversations this practice is likely to appear problematic; however, in the medical context it is often accepted as part of the history-taking phase of the consultation.
7. Single question multi-unit turns with a gist formulation or summary statement followed by a question may be more likely to receive an answer than questioning turns that contain more than one question.

8. Consistent with other CA research (e.g., Heritage, 2010; Raymond, 2010; Stivers, 2007), my findings suggest that openness of questions is not a simple dichotomy of open- versus closed-ended questions. Rather, questions have varying degrees of openness depending on question design and content. That is, problem attentive, positively polarized YNIs that enquire about a specific aspect of pain are more open than other YNIs, YNDs and ALT-Qs. Further, how, why and what questions are more open than when, where and who questions. Non-specific how questions (i.e., asking about pain in a general sense) posed near the beginning of a consultation are more open than other wh-questions asked at this point in the consultation.

9. Consistent with other CA research (e.g., Boyd & Heritage; Stivers & Heritage, 2001), I found that close-ended polar questions can be suitable and informative when used for certain purposes. For example, these types of questions can aid in the progressivity of the talk during physical examinations when physicians need to quickly collect specifics about patients’ situations. Asking concise and often truncated closed-ended questions (e.g., “Any pain in your back?”, “In here?”, “Here?”) allows physicians to progress efficiently through a checklist of standardized questions (see Stivers & Heritage, 2001).

10. Claiming social entitlement or ownership over the talk regarding their physical experiences might be one of the few instances in which palliative patients have
any control over their experiences. My findings concerning problem attentive
YNI’s and WH-questions support the suggestion by Raymond and Heritage
(2006) that these types of questions can avoid intervening unduly into the
“territorial preserves” (p. 700) of the patient.

Overall, my findings underscore the challenge of formulating questions in a way
that will elicit the most useful information about a patient’s experience of pain. They
emphasize the necessity of considering the grammatical design of questions, their
content, their sequential placement and the relationships among these. At the same time,
these findings point to a number of ways in which practitioners can try to ensure that their
questions about pain are as effective as possible. As stated in Chapter 1, effective
communication with patients with a life-limiting illness can significantly increase
patients’ quality of life and satisfaction with care (Billings, 2000). Further, research
shows that physicians benefit from enhanced communication with terminally ill patients
in that they report increased career satisfaction, decreased risk of burnout, and less stress
regarding possible threats of litigation (Bradley & Brasel, 2008; Schapira, 2004).

Future Research

The present study examined only a small portion of the larger corpus of data from
the palliative care clinic. Additional analyses are needed on question and answer
adjacency pairs, aspects of pain and patterns of elaboration with the larger data corpus.
These analyses would provide support for or help to revise my findings. Also, I plan to
examine the data corpus for other topics such as displays of alignment, affiliation and
empathy; the sequential organization of talk regarding the management of palliative
patients’ optimism and reframing hope; enactments of psychosocial support; sequential
organization of the delivery of bad news; displays of patient (dis)satisfaction with the quality of services provided; and enactments of patient-centred care in a palliative care context. Findings from research on these topics have implications for quality improvement of palliative care services and the training of residents and physicians.

In addition to research using the existing data corpus, collection of data from home palliative services and/or inpatient palliative care (e.g., hospitals, long-term care facilities and hospice) would allow for comparison of physician/patient interactions in different palliative settings. Further, performing more explicit comparisons between physician/patient interactions (e.g., what constitutes as an optimal health outcome) in palliative care and other medical contexts (e.g., surgical units, hospital emergency rooms, and the examining rooms of pediatricians, family practitioners, neurologists, etc.), would help physicians and researchers to understand possible subtle and/or explicit differences/similarities in physicians’ assessment of and patients’ talk about pain.

Conclusion

I have demonstrated some of the difficulties involved in designing questions about physical pain for the palliative care context, wherein information is sought about a complex experience with multiple features that is difficult to describe under any circumstances. This study shows that question design and content are critical with respect to the type of information that is obtained from palliative patients about their experiences of pain. That is, that some discursive practices more than others can encourage elaboration of patients’ experiences of pain. In addition to considerations of question design and content, there is the challenge of formulating questions for multiple types of visits (i.e., new concerns, follow-up visits and chronic-routine) during one consultation.
For physicians to be more effective at obtaining desired information, they need to first consider the type of answer they are looking for (e.g., elaborated telling or concise answer) and then use research findings to help guide them on how to tailor their approach to assessing patients’ pain in an efficient manner.

It is my belief that the present study fills some gaps that were identified in the current literature regarding the dynamics of physician-patient interactions in palliative care. My CA research identified process-related phenomena (e.g., patterns of elaboration related to question design) in naturally occurring palliative care interactions that have not been examined in the existing palliative care empirical literature. Also, my findings go beyond those presented in other research conducted in a palliative care context that used traditional research approaches such as questionnaires and retroactive interviews with patients and family members. That is, I showed the ways in which question design and content, and the sequential context of the questions had implications for the type of answers/responses the patient provided. Finally, my focus on the medical speciality of palliative care builds on the existing CA medical corpus of research that is primarily focused on acute/primary care consultations and other specialities.

Postscript

When I embarked on this research I naively believed that I would have no difficulty in maintaining an objective perspective during data analysis. I understood that I would witness a dying patient talking about his experiences. What I did not consider was that even though I had no physical contact with the patient in this study, listening to his story and watching the changes in his physical condition (over the course of the one year
of data collection) challenged my ability to consistently remain objective while writing up my analyses.

By allowing me to analyze his consultations for my dissertation, the patient shared with me many personal aspects of his life. This gift gave me the opportunity to empathize with his frustration regarding his disease and his desperation for a reprieve from his palliative status. Also, I was witness to the physical hardship the cancer imposed on his body. The two years I spent doing and writing up my analyses gave me a deeper understanding of the interactions he had with the various physicians. My emotional responses to the suffering of the patient meant that on several occasions I had to remind myself to be objective, neither substituting my interpretation of the talk for that of the participants nor being judgemental of the physicians. Thankfully, my advisors reminded me that the physicians are doing a difficult job and that the residents were not experienced in doing palliative consultations; they were learning, as was I.
References


Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN


Yedidia, M. J. (2007). Transforming doctor-patient relationships to promote patient-
Appendix A: Glossary

**Action agenda:** The particular restricted action that the speaker is requesting of the recipient by the type of question that is asked.

**Adjacency pair (AP):** The basic features of an AP and its mode of operation are: a) consists of two turns; b) has two speakers; and c) the turns are adjacently placed (i.e., one turn after another). The two turns are ordered in relation to each other in two ways. First, they consist of first pair parts (FPPs) and second pair parts (SPPs) and the two parts must be related to each other (i.e., the SPP must be the proper type of follow-up to the FPP). Second, APs are ordered into “pair types” (Schegloff, 2007, p. 14). That is, FPPs can be identified as particular types (e.g., questions, offers, greetings, requests) and each type of FPP has a corresponding SPP type. Same pair types include such APs as questions and answers, offers and acceptance or declining, greetings and greetings, and requests and granting or rejection. Non-same pair types would be such instances as responding to a question with a greeting or responding to a greeting with a rejection. Same pair types aid in the continuity and the progressivity of the talk because the talk is able to move uninterrupted from some element, such as a question, to a hearably next element, an answer. If some utterance or sound interferes with the continuity of a same pair type, “it will be heard as qualifying the progressivity of the talk, and will be examined for its import, for what understanding should be accorded it” (Schegloff, 2007, p. 15).

**Affiliation:** Affiliation is an action produced by a recipient of a speaker’s talk that demonstrates to the teller that the recipient has access to and understands the speaker’s stance and that the recipient endorses and supports the speaker’s perspective.

**Agenda:** Consists of two components: topic and action. The topic agenda of a question is the particular issue to which the question is addressed. The action agenda is the particular restricted action that the speaker is requesting of the recipient by the type of question that is asked.

**Agenda-transformative responses:** These types of responses work to transform the question’s focus, bias or presuppositions, and in effect to reject the design of the question. The degree to which a recipient resists the agenda of a speaker’s question can be placed on a continuum from least to most resistant, depending on what the recipient does to the agenda of the question.

**Alignment:** Alignment is an action produced by a recipient of a speaker’s utterance that acknowledges the information the speaker provides and that supports the progress of the sequence of talk.

**Alternative questions (ALT-Qs):** These types of questions offer the recipient a set of possible answers in the form of two or more alternatives, and usually a direction to the recipient to choose among the provided choices. The action agenda of ALT-Qs calls for a repetition of one of the proffered alternatives (i.e., a type-conforming answer).
**Applied conversation analysis:** Follows the same general principles as pure CA. However, institutional settings impose special constraints on the interaction that are not necessarily present in ordinary conversational settings. That is, the goals of ordinary conversations largely depend on the particular participants; therefore, the goals are broad. In contrast, an interaction between a physician and patient has a specific goal that is oriented to the distinct sequential organization of turn allocation (i.e., repetitive cycles of questions and answers) that is preferred by this institutional setting.

**Clausal response:** Answers to WH-Qs that contain the appropriate phrasal response or finite noun and also contain additional units of talk. The additional talk in clausal responses “indicate some trouble with the sequence. Through their clausal form they may treat the question as inapposite in some way or may suggest that the answer is in some way not straightforward” (Fox & Thompson, 2010, p. 138).

**Conversation analysis:** The goal of CA research is to study (i.e., observe, describe, analyse and understand) aspects of social life (e.g., talk and non-verbal actions) in which people are collaboratively working to accomplish something. CA focuses on naturally occurring turn-taking interactions between people as a means of understanding how conversational utterances “accomplish actions and activities without necessarily formulating them as such” (e.g., informing, complaining, giving advice, describing, requesting) (Maynard & Heritage, 2005, p. 429). CA is data-driven, using naturally occurring interactions rather than those that are artificially produced (e.g., in experiments). The basic approach of CA is inductive (i.e., the process of using naturally occurring data to “formulate or reformulate a general idea;” ten Have, 2007, p. 37).

**End-of-life care:** Synonymous with hospice care.

**Epistemic stance:** In every interaction between two or more people, at least one person in the interaction is in a position of some knowledge regarding a topic that is discussed. Epistemic stance is “how speakers position themselves in relation to each other in and through the design of their turns at talk” (Heritage in press b, p. 2). That is, by virtue of asking a question that seeks information, a speaker positions himself/herself in a relatively unknowing (K-) epistemic stance in relation to a projected knowing stance (K+) of the recipient for the topic being discussed.

**Expanded answers:** Involve the recipient providing the required answer and a brief elaboration.

**Generalizability:** CA analysis of single-cases and collections of specific phenomena provide a grounded basis for “developing generalizable descriptions of communication phenomena” (Beach, 2009, p. 36). Through the process of constant comparison of new data with that of existing analyses, CA researchers are able to “examine how larger collections of instances reflect generalized actions and patterns across diverse settings, speakers, topics, and cultures” (p. 36).
**Hospice care**: The overall support and care (i.e., physical, psychological, social, cultural and spiritual) of persons with a life-limiting illness at the end of life.

**Multi-unit questioning turns at talk**: Turns that involve more than one turn construction unit (TCU) and that contain at least one question seeking information. They can also include assessments, announcements and/or assertions.

**Narrative expansions**: These types of expansions are recipient-initiated, are not part of the answer to the just prior question (nor part of clarifying a just provided answer). In physician-patient interactions, they usually involve the patient giving the physician some insight into the patient’s life circumstances. These expansions take one of two forms: a small scale telling or a full-blown narrative.

**Overall structural organization of an interaction**: After marking the transition relevance places (TRPs) and turn construction units (TCUs), the next step would be to construct an overall map of the interaction with an emphasis on its typical phases or sections (e.g., beginning, middle, end, transitions between topics). The map should not be seen as a fixed analytic framework into which future data are slotted, but as an evolving process that the participants orient to when organizing their talk.

**Palliative care**: Often referred to as comfort care because it is largely focused on the management of specific symptoms (e.g., pain, nausea, constipation) during the process of dying. This care also provides patients with opportunities to partake in autonomous decision-making and to gain as much enjoyment as possible from their life while they are dying.

**Phrasal response**: Answers to WH-Qs that are limited to a grammatical phrase (e.g., ten miles) and that answer the question in a concise manner with little elaboration. Phrasal responses indicate that the recipient views the action and topic agendas of the question and the presuppositions inherent in the question as acceptable.

**Preference**: Preference is generally a bias toward a particular type of answer to the first pair part (FPP) of an adjacency pair (AP). For example, an invitation prefers an acceptance, a request prefers a granting, and a question prefers an answer. In the case of questions, there are two main types of preference: they may be designed to favour, prefer or suggest an expectation for one type of answer (i.e., type-conforming) and/or one specific answer over another. First, there is a preference for a type-conforming answer over a non-type-conforming answer. That is, yes/no interrogative (YNI) and yes/no declarative (YND) questions prefer a yes- or no-type answer, WH-Qs make relevant or prefer a specific type of answer (e.g., who questions make relevant a person or people reference as an answer, where questions make relevant a place or position reference as an answer, etc.), and ALT-Qs prefer the repetition of one of the proffered answer options. Non-type-conforming answers are dispreferred because they reject the agenda-setting function of the question. Second, for YNIs and YNDs, grammatical design and polarity can influence the preference for one specific answer over another. For example, words
such as *any, ever, at all* have a negative polarity, thus they prefer a *no*-type answer. WH-Qs and ALT-Qs do not display a preference for one specific answer over another.

**Presuppositions:** All questions include presuppositions or assumptions about aspects of a speaker’s life circumstances with varying degrees of explicitness.

**Principle of optimization:** Physicians’ questions that embody this principle incorporate presuppositions and preferences that are biased towards best case or no problem outcomes for the patient’s health or life circumstances. A question displays the principle of optimization when the content of the question and the preferred response are aligned toward a positive health outcome.

**Principle of problem attentiveness:** If a patient mentions a particular symptom, then the physician should design questions that are broadly in line with that symptom and that are designed to presuppose there is a problem (i.e., display the principle of problem attentiveness).

**Principle of recipient design:** The default principle for ordinary conversations is the principle of recipient design. That is, speakers design their talk to display an “orientation and sensitivity to the particular others who are the co-participants” in the conversation (Sacks et al., 1974, p. 727).

**Pure conversation analysis:** Examines talk-in-interaction during “ordinary conversations. Pure CA analysis adds to our knowledge of how social order is accomplished. Emphasis is placed on how sequence and context are linked; that is, as participants are designing their turns-at-talk (next action) they orient to the talk preceding their turn, consequently constructing and reconstructing a context for the next speaker. The production of a next action demonstrates an “understanding of the previous action, building mutual understandings or intersubjectivity” (ten Have, p. 179).

**Reliability:** In CA reliability is achieved via exemplars of a claim from naturally occurring data. Exemplars from naturally occurring interactions are akin to “replications of experimental findings.”

**Repair organization:** Analysis of repair organization involves examining “various kinds of trouble in the interaction’s progress such as problems of (mis)hearing or understanding” (ten Have, 2007, p. 133). Often the trouble source creates an urgency that can lead to “a postponement or abandonment of the projected next action” (ten Have, p. 133). There are several ways in which a repair can be recognized and performed: self-initiated self-repair, self-initiated other-repair, other-initiate self-repair, and other-initiated other-repair.

**Routine checklist-type questions:** The routine checklist activity usually involves the physician asking the first question as a fully formed yes/no interrogative (YNI) or yes/no declarative (YND); each successive question then becomes more truncated than those prior in a process of ellipsis.
Same pair types: Adjacency pairs (APs) in which the second pair part (SPP) is relevant to the first pair part (FPP). Same pair types include such adjacency pairs (APs) as questions and answers, offers and acceptance or declining, greetings and greetings, and requests and granting or rejection. Non-same pair types would include such instances as responding to a question with a greeting or responding to a greeting with a rejection. Same pair types aid in the continuity and the progressivity of the talk because the talk is able to move uninterrupted from some element, such as a question, to a hearably next element, an answer. If some utterance or sound interferes with the continuity of a same pair type, “it will be heard as qualifying the progressivity of the talk, and will be examined for its import, for what understanding should be accorded it” (Schegloff, 2007, p. 15).

Sequential organization: Ordered progression of turns, often based on adjacency pairs.

Single-unit questioning turns at talk: Question-answer adjacency pairs (Q/A-APs).

Topic agenda: The topic agenda of a question is the particular issue to which the question is addressed.

Transition relevance place (TRP): “A moment in the turn-at-talking in which that turn might be possibly complete and another speaker might take over;” (ten Have, 2007, p. 219); occurs at the end of any turn constructional units.


Turn constructional unit (TCU): “The part of an utterance that might be a complete turn, after which another speaker might take over;” (ten Have, 2007, p. 219).

Turn design: Turn design has two components: the action the talk in a turn is designed to perform (e.g., gain information, inform, persuade) and the means that were selected by a participant to perform that action (e.g., a physician asks a series of closed-ended questions; the patient expands an answer to a closed-ended question to introduce another topic). Turn design contributes to sequential organization because the design of each turn can make relevant a particular type of response (e.g., a question by the first speaker makes relevant an answer by the second speaker). In turn, sequential organization “contributes to the phases of interaction which make up its overall structural organization” (Heritage & Clayman, 2010, p. 50).

Turn-taking organization: This involves one person talking at a time with a minimal gap or overlap before speaker change. Turn-taking assists participants to fine-tune and actively adapt the talk to co-construct a continuous interactional achievement. In the analysis of interaction, emphasis should be placed on how, if at all, participants display a
shared normative orientation in their turn-taking that could be attributed to the sequential context.

**Type-conforming answers:** Are those made relevant by questions. For YNIs and YNDs, the type-conforming answer is the word *yes* (or an equivalent) or the word *no* (or an equivalent). For WH-Qs (i.e., *who, what, where, when, why*, and *how* questions), the type-conforming answer is the information made relevant by the type of WH-Q (e.g., the name of a person, place or thing for a *who* question). For ALT-Qs, the type-conforming answer is the choice of one of the provided options.

**Validity:** In CA validity is demonstrated by the “convergence between the researchers’ and participants’ perspectives. A phenomenon disclosed by a researcher must be a phenomenon to the participants” (Orletti, 1989, p. 76). The empirical findings in CA research are grounded within the recordings of naturally occurring, real time interactions and are illustrated through excerpts of detailed transcripts of the talk. The data are not “idealized, hypothetically derived, self-reported, and/or reconstructed choices and actions ‘driven’ by participants motives, needs, or other observer imposed phenomena” (Beach, 2009, p. 36). Validity of a researcher’s interpretation is tested by “tracking how the participants themselves make sense of their talk and comparing exemplars against other exemplars” (Gale, 1989 as cited in Ratliff, 1992, p. 8).

**WH-questions (WH-Qs):** Are questions that ask *who, what, where, when, why* or *how*. WH-Qs are considered open-ended questions and “are seen as encouraging patients to respond in their own terms and permitting the emergence of narratives based on lifeworld experience” (Boyd and Heritage, 2006, p. 157).

**WH-Qs specifying questions:** These types of questions seek specific pieces of information from the recipient, who is expected to answer in a concise manner with little elaboration.

**WH-Qs telling questions:** These types of questions seek extended or elaborated answers from recipients (e.g., reports, stories, accounts).

**Yes/no declarative (YND):** A speaker uses a declarative question as a way of making an assertion or claim about a matter when he/she assumes to know about the matter, but would like to have the assumption validated. The use of a declarative question makes relevant a confirmation from the recipient.

**Yes/no interrogative (YNI):** A speaker initiating an action using interrogative form communicates to the recipient that he/she is uncertain about some piece of information, thereby making relevant an “answer” from the recipient.
Appendix B: Communication Criteria for Palliative Rotation

On completion of the rotation, the family medicine resident will be able to assess and manage pain and symptoms and psychosocial/spiritual needs.

1. Assess pain and symptoms effectively via a pain history, appropriate physical exam and relevant investigations.
2. Prescribe opioids effectively including initiating dosage, titration, breakthrough dosing and prevention of side effects.
3. Prescribe adjuvant modalities and medication for pain.
4. Participate in the development of interprofessional management plans for other symptoms including fatigue, anorexia and cachexia, constipation, dyspnea, nausea and vomiting, delirium, anxiety and depression.
5. Monitor the efficacy of symptom management plans.
6. Record a holistic management plan.
7. Demonstrate the ability to develop a management plan that appropriately balances disease-specific treatment and symptom management according to the individual needs of the patient and family.
8. Identify and assess psychosocial and spiritual issues in end-of-life care and develop and implement a care plan to address in collaboration with other disciplines.
9. Self-assess one’s own attitudes and beliefs in caring for the dying and how they impact the care provided.
10. Demonstrate cultural, religious and aboriginal sensitivity in addressing end-of-life care.
11. Demonstrate the role of the family physician in assessing and managing grief in patients and families.
12. Determine, record, revise and implement goals of care through effective communication with patient, family and other caregivers.
13. Discuss advance care planning, including developing, revising and implementing advance directives with patients and families.
14. Discuss withdrawal and withholding of therapy.
15. Describe models of end-of-life care and the provision of such care.
16. Distinguish between physician assisted suicide and euthanasia and terminal sedation, and withholding and withdrawing therapy.
17. Communicate information about the illness effectively including bad news.
18. Initiate and participate in effective patient and family meetings.
19. Educate patients and family about end-of-life care issues and pain and symptom management.
20. Demonstrate the ability to define the elements of suffering in end-of-life care for patients, families and caregivers.
21. Describe and implement a supportive approach to suffering.
22. Demonstrate an ongoing commitment to a patient and family at end-of-life.
24. Identify patient and family’s understanding of disease.

100 Provided by the Temmy Latner Centre for Palliative Care, Mount Sinai Hospital, Toronto, Ontario (2011).
Appendix C: Edmonton Symptom Assessment Survey (ESAS)

Guidelines for using the Edmonton Symptom Assessment System (ESAS)

Purpose of the ESAS

This tool is designed to assist in the assessment of nine symptoms common in cancer patients: pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, wellbeing and shortness of breath, (there is also a line labelled “Other Problem”). The severity at the time of assessment of each symptom is rated from 0 to 10 on a numerical scale, 0 meaning that the symptom is absent and 10 that it is of the worst possible severity. The patient and family should be taught how to complete the scales. It is the patient’s opinion of the severity of the symptoms that is the “gold standard” for symptom assessment.

The ESAS provides a clinical profile of symptom severity over time. It provides a context within which symptoms can begin to be understood. However, it is not a complete symptom assessment in itself. For good symptom management to be attained the ESAS must be used as just one part of a holistic clinical assessment.

How to do the ESAS

The patient circles the most appropriate number to indicate where the symptom is between the two extremes.

No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible pain

The circled number is then transcribed onto the symptom assessment graph (see “ESAS Graph” below).

Synonyms for words that may be difficult for some patients to comprehend include the following:

Depression - blue or sad
Anxiety - nervousness or restlessness
Tiredness - decreased energy level (but not necessarily sleepy)
Drowsiness - sleepiness
Wellbeing - overall comfort, both physical and otherwise; truthfully answering the question, “How are you?”

When to do the ESAS

a) In palliative home care, it is a good practice to complete and graph the ESAS during each telephone or personal contact. If symptoms are in good control, and there are no predominant psychosocial issues, the ESAS can be completed weekly for patients in the home. In hospice and tertiary palliative care units the ESAS should be completed daily. In other settings the palliative consultants will utilize this tool in their assessment on each visit.

b) If the patient’s symptoms are not in good control, daily assessments need to be done in person by the attending health professionals until the symptoms are well-controlled (see “d” below).

c) If symptom management is not attained, or consultation about possible care options is needed, patient assessments by Palliative Care Consultants are available (attending physician must agree). Consultative discussions not requiring in-person patient assessments are available from Palliative Care Consultants upon request.

d) If, after all therapeutic options have been exhausted and consensus is reached that a symptom cannot be further improved, visits and assessments can return to their normal pattern for that patient.
Who should do the ESAS

Ideally, patients fill out their own ESAS. However, if the patient is cognitively impaired or for other reasons cannot independently do the ESAS, then it is completed with the assistance of a caregiver (a family member, friend, or health professional closely involved in the patient’s care). If the patient cannot participate in the symptom assessment, or refuses to do so, the ESAS is completed by the caregiver alone.

Note: when the ESAS is completed by the caregiver alone the subjective symptom scales are not done (i.e. tiredness, depression, anxiety, and wellbeing are left blank) and the caregiver assesses the remaining symptoms as objectively as possible, i.e. pain is assessed on the basis of a knowledge of pain behaviors, appetite is interpreted as the absence or presence of eating, nausea as the absence or presence of retching or vomiting, and shortness of breath as laboured or accelerated respirations that appears to be causing distress for the patient.

When a patient is cognitively impaired and cannot participate in doing the ESAS, the caregiver continues to complete the ESAS as outlined above.

The method in which the ESAS was completed must be indicated in the space provided at the bottom of the ESAS Numerical Scale and the ESAS Graph as follows:

<table>
<thead>
<tr>
<th>Bottom of ESAS Numerical Scale</th>
<th>Bottom of ESAS Graph</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed by (check one)</td>
<td>Completed by [ ]</td>
</tr>
<tr>
<td>Patient</td>
<td>Key:</td>
</tr>
<tr>
<td>Caregiver</td>
<td>P = Patient</td>
</tr>
<tr>
<td>Caregiver - assisted</td>
<td>C = Caregiver</td>
</tr>
<tr>
<td></td>
<td>A = Caregiver - assisted</td>
</tr>
</tbody>
</table>

Where to document the ESAS

The ESAS is always done on the ESAS Numerical Scale and the results later transferred to the ESAS Graph. Graphing symptom severity directly onto the ESAS Graph without the use of the numerical scale is not a valid use of the ESAS nor a reliable method of symptom assessment (attention to the graphed historical trend may affect the current scores and so undermine one of the main purposes of the ESAS, i.e. to assess the current symptom profile as accurately as possible).

Other Information About the ESAS

The ESAS Graph also contains space to add the patient’s Mini-Mental Status Exam score. The “normal” box refers to the normal range for the patient, based on age and education level (see Instructions for MMSE). As well, a space for the Palliative Performance Scale (PPS) is included. The ESAS is available in other languages and also in faces for those patients who do not read.
Edmonton System Assessment System: Numerical Scale
Regional Palliative Care Program

Please circle the number that best describes:

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
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<td>No pain</td>
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<td></td>
<td></td>
<td></td>
<td>Worst possible pain</td>
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<tr>
<td>Not tired</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Worst possible tiredness</td>
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<tr>
<td>Not nauseated</td>
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<td></td>
<td></td>
<td>Worst possible nausea</td>
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<td>Not depressed</td>
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<td>Worst possible depression</td>
</tr>
<tr>
<td>Not anxious</td>
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<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Worst possible anxiety</td>
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<tr>
<td>Not drowsy</td>
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<td>Worst possible drowsiness</td>
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<td>Best appetite</td>
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<td></td>
<td></td>
<td></td>
<td>Worst possible appetite</td>
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<td>Best feeling of wellbeing</td>
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<td></td>
<td></td>
<td>Worst possible feeling of wellbeing</td>
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<tr>
<td>No shortness of breath</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst possible shortness of breath</td>
</tr>
</tbody>
</table>

Patient’s Name ____________________________

Date _______________ Time _______________

Complete by (check one):

☐ Patient
☐ Caregiver
☐ Caregiver assisted

BODY DIAGRAM ON REVERSE SIDE

25. CH-0202 May 2001
Please mark on these pictures where it is you hurt.
### Edmonton Symptom Assessment System Graph (ESAS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiredness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drowsiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appetite</td>
<td></td>
<td></td>
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<tr>
<td>Wellbeing</td>
<td></td>
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<tr>
<td>Shortness of breath</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>Mini-Mental (Normal)</td>
<td></td>
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<tr>
<td>PFS</td>
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</tbody>
</table>

**Completed by:**

- **P** = patient
- **C** = caregiver
- **A** = caregiver-assisted

**Level of Education**

**Cage Score**

**CH 12006 May 2001**
Appendix D: 28 Sequences of Pain Talk

Sequence 1:

Clip: C3P2 RP DA LL 60-123

R: So I just wanted to start out,
   (.)
   u::m:
   (0.5) ((Papers shuffling))
   with the form that you filled out today?,
   P: ((Nods head up and down slightly))
   (0.4)
   R: I noticed 
   (.)
   a ↑ Couple things ↓ had changed from the last time um,
   (0.3)
   R: SOME for the-a >little bit< better? and some a little bit worse.
      •hhh So::: I jus wan:ted to know how how YOU'RE feeling and
      (.)
      and what symptoms are bothering you right now.=
      P: =Ah:::
      (0.4)
      no ↑ I've:::
      (.)
      I'm not feeling worse?,
      R: ((Nods head up, down, left, right and down))
      (1.2)
      P: =I would say ah:
      (1.0)
      n:-no changes since the last time.=
      R: =↑ O↓ kay.
      (0.2)
      •hhh In terms of the pain?, there's no change.
      (.)
      P: U::m
      (.).
      I don't zink so no no it is not worse=,
      R: =↑ O↓ kay.=
      P: =right now.
      (0.3)
      R: Very good. •hh In FACT You ranked it as:::
         a ↑ little ↓ even {bit better than the last time ar-around,
         >do you think that that's the truth?,< or
         {somewhere $(hh)huh probably about the same$=.
         P: {((Nods head up and down slightly))}
         =It could be yeah::.
         (.)
      R: Okay. ↑O↓ kay. •hh Ah >↑what are you using< ↓for the pain right now.
         (0.6)
      P: pt U:::m
         (1.2)
         Tylenol three?
Sequence 2

Clip: C3P2 RP DA LL 732-778

R: And was there
   (0.3)
   anything else helpful that you were hoping we could do for you here today.
   (0.2)
   In today's visit.
   (2.2)

P: Ahs no "hu-hu-[hu.]"

R: [Huh] hhh.

P: I do not (have)
   (0.5)
   may be not right now. "You know" not a lot of changes right "now,"
   (0.3)
   "on that" =

R: But I think that's all: that's all you: did right?
   hhh That
   (.)
   the pain is not any worse?
   That the breathing's not any worse?,=

P: [Ah-]

R: =That [these things] are all going {{ well}}.

P: {[Ye:: ah: ]} [(Cuz)]

R: =No[thing "works then" ]

P: [(A g(h)ood(h) (h)one) huh] hhh

R: Fair(h) e(h) enough(h).

Sequence 3

Clip: C6P2 RP DA VT LL 9-61

R: Ah
   (.)
   but I always wanted to:
   (.)
   start out by asking
   >if there's anything that's on< your agenda.
   (.)
   Any things you wanted to bring up today.
   (1.4)
   Major issues:::
   (1.9)

P: I dunno, I "usually come here to::
   (1.0)
   <manage> ah my pain.

R: ((Nods head))
   (.)

P: U:m
   (1.6)
"yeah"
((sniff))
(0.8)
(that's about it) "yeah".
(0.5)
R: Okay. •hh
(.)
>{Do you have any issues that you wanted to bring up?, with regards to your pain?,
this week.
(1.5)
P: M:: uah:: it hasn't changed a lot
(.)
m::
(.)
m::
(0.2)
°in the last hm°.
(1.7)
May be I'll get a refill:: or::: ah:
(0.2)
some medications, something like 
(0.2)
prescription.

Sequence 4:
Clip: C6P2 RP Da VT LL 99-200
R: Okay so you're going back in again on Monday
P: May be they want to check after. I don't know.
R: Uh huh
P: So.
R: How is your:
(.)
pain after this last chemo session?,
(1.2)
P: :It hasn't changed ah::
(0.7)
°I dunno°.
(0.2)
With this new chemo I: I usually ah
(.)
I::-I have more pain:, 
(0.4)
R: [ O:kay ].
P: [>especially<] in my pelvis.
(0.4)
R: Yes.
(0.7)
P: I have so,
(0.9)
I dunno if this for better or for worse.
(0.7)
°But ah°
(0.3)
the only way is to check
(by a CT scan I think).

R: "Right".

•hh >And so< your perception is that
the pain has been constant. It hasn't
decreased or it hasn't increased
in with this last session?

P: =>Yeah yeah it< increased when: they began
[the new] chemo?,

R: [ Right ]

P: and there it is:::,
or else
the same lef,

R: [So it had gone ↑
at the start of the sessions.=

P: =Y:eah.

R: ↑Ok↓ ay.

P: I'm usually I have pain when I am SITtin.

R: Yep.

•hh [You're sitting's]

P: [ But not ↑not ]
when I am standing, when I am standing where's
no pressure so as
no-
almost no pain.

R: Okay.

•hh Now I notice that yer <sitting::> u::m
a little bit tilted, is that
normal for >you?,

313
Sequence 5

Clip: C6P2 RP Da VT LL 207-291

P: Ah:::

R: [Do you] feel like you sit <more>

(0.3)
on your
(0.6)
on your ah sit bones ↑now↓ than you did before?
(1.1)
P: Ah
(.)
>um ah< the same more or less.
(.)
R: ↑Ok↓ kay.
(3.0)
↑Ok↓ kay.
(,)
•hhh When we looked at [ your:: ]

P: [>I have a<] tumour there.

(0.4)
R: Yes.
(.)
No I understand that.
(.)
•hhh >Well when we<
(.)
a- we were just looking, just as a casual observation for you.
(0.2)
•hhh When we look at your
(0.3)
your u:m: pt symptom ↑assessment↓ report
(0.5)
u::m
(,)
your pain is constant. It was
(0.2)
two the last time, it's two this time.
(0.2)
•hhh U::m:
(1.0)
but you
(.)
you seemed >to have<
(0.3)
<been: more> aggressively ↑show↓ ing
(0.6)
ah::: just the symptoms were
(.)
a-or may be more so there the last time.
>That could< just be::
(.)
↑how↓ you were drawing but,
P: >I-i-i< just ah:::
   (1.1)
   I just
   (0.2)
   u:::
   (0.2)
   draw the area more or less i-i-it does[n't me]an=
R:                                          [ Yeah.]
P: =that i-it=
R: =it's [>more severe less severe<. :O,kay].
P: [ intensity.        Yeah ]
   (0.4)
R: Good enough::.
   Ah we did notice that there's a few things
   that have changed so would you mind if I just
   reviewed um [your symptoms] as well
P: [okay hm]

Sequence 6

Clip: C6P2 RP DA VT LL 298-363
R: And how much of the medication are you currently taking?
P: Ah two pills of oxycotton ten milligrams.
R: Okay. And how is that helping your pain?
   (0.7)
P: ↑Ah it's ↓ah yeah
   (0.2)
   it's::: >more or less<
   okay yeah.
   (0.6)
R: So when you take the medication
   (0.3)
   do you have relief?
   (1.2)
P: °Hm.°
   (0.4)
   Yeah.
   (0.5)
   It's:::
   (0.9)
   Yeah
   (0.4)
   I have relief.
   (0.4)
R: °Okay°.
   (0.4)
   hh I mean-
   (0.4)
   does it get from like
   (1.2)
   >does it ever get down to< zero or do you always have
   (0.3)
   °pain°?
   (0.7)
P: Ah:::
I have pain more >when when< I am sittin'.

R: Yes.

P: So::: I don't want to take a lot of pain
>medica-I don< want to take a lot of
(0.2)
chemicals.
(.)
[I have enough] chemicals so:::
R: [ Ye:::ah ]
(0.6)
R:→ Okay.
P: The chemo.
R: Are you using any of the breakthrough pain medications?

Sequence 7
Clip: C6P2 RP DA VT LL 459-510
R: Ah and potentially some renewals of medication.
Some
(0.4)
proA ctive ways of: helping to keep your bowels steady.
P: ($(Nods head up and down slightly three times))
(1.2)
R: Okay.
(0.2)
•hh >WAS there anything else in particular that<
you <wanted> to bring up today or?, or a-<address today?
(0.2)
P: (Sniff)
(1.0)
("pt No good news").
(0.8)
R: Has there been any n::ew pain that's come up
(0.3)
apart from >the-your< regular [pain].
P: ["No"].
I had enough.
(0.4)
R: HhhhHA •UH:::
(.)
$N:o new pain$.
(0.7)
I understand.
(0.4)
No chest pain or palpitations,
(0.5)
P: ["No"].
(0.8)
R: °Okay°.
(0.6)
Excellent.
>TI-no difficulties< with breathing, shortness of breath.
P: ($(Shakes head side-to-side slightly))
R: °Okay°.
(0.2)
P: °°No°°.
(0.5)
R: °Good°.
(0.4)
So >there's a few things< that I'd like to do
on physical exam today

Sequence 8

Clip: C8P2 RP D VN LL 37-116
R: U:m: we can just start from:
(0.2)
what's been going on since your last visit.
(0.2)
P: ((Nods head up and down))
(0.7)
R: U::m::: so couple things I wanna know is how is your pain.
(1.3)
P: U::m
(2.0)
I still have pain.
(0.5)
Yeah.
(1.5)
U::m
(0.3)
but I having better that it's stopped growing
in my:::↑ah:::↓ah: my pelvis.
(0.2)
Cuz I had radiation.
(1.0)
R: [Excellent].
P: [I:- I ] can feel it how: ↑ho:w:a
(0.7)
I felt how it was growing before.
(0.5)
Ah: so I I couldn't sleep.
(1.0)
Ah:
(0.2)
had to:::↑w::um:?,
(0.6)
wake up
(0.8)
you know
(0.3)
m:~make some exercises ah::: during the __ before?
(0.3)
(0.6)
But now::: I::: can sleep better
(0.3)
why I sink
(1.0)
Running Head: QUESTIONS AND ANSWERS ABOUT PHYSICAL PAIN

u:::m:
(0.7)
it stopped
(0.5)
R: {((Nods head up and down))}
P: {at least (stop. I don't know). Yeah.}
(1.1)
R: :Good.[That's great].
P: [ U::::::m ].
(0.8)
R: [You ma-]
P: [ (On) ] this Monday::: I: have the CT scan.
(0.3)
R: Uh hm.
(0.2)
P: At u:::m:
(0.5)
Hospital?, what I was sent from the:
>ah what is it< CT scan
(0.5)
from the (name) Hospital.

Sequence 9

Clip: C8P2 RP D VN LL 137-272
R: And the reasons you feel like i-i-
(0.2)
you know the radiation has
(0.2)
has helped is that y-y-your sleep is [{ better].
P: [{Ah yeah}.
{(Nods head up and down)}
(0.2)
My sleep is better.
(0.6)
R: Okay.
(1.)
And your pain is::
(1.0)
P: m::
(0.2)
R: about the same it sounds like.
(0.9)
P: This-
(0.2)
now it is different.
(0.6)
R: [Oka[y]
{(Nods head up and down)}
P: [A]fter radiation the-u-i:::t's:: some kind different ah.
(1.9)
R: Tell me how your pain's different.
(1.1)
P: I:-I:-it's PAin is always ah something like present but it
is something like different. I don't know how. But i-
ah i- it was different before?
(0.3)
R: [Hm: ]

P: [After] the radiation it became different because of the radiation.

R: So before the pain may be you can tell me like a-a- is [it]

P: [It] was growing. It was growing and pressing my nerves.

R: OKay.

P: And ah::: so:::?, I was feeling how:: my my legs were

R: Right.

P: An so::: ah::::?

R: I see now that my::: may be my legs ar[:][::e]

P: better now, so I:: think >it is not< pressing on my nerves.

R: I [understand].

P: [ as much ]. That's why I [wasn't],

R: [ Okay ].

Okay. And so INstead of the having the pain: pressing on your nerves what's the pain feel like now?,

P: Now:ah how i-it's like PREsent ah-i-i-[it's present ]

R: [It's just the]r:e.

P: I-ju-it's there ye[ah ( )]

R: [Okay. And is the pain] a-

P: >Not not< the::: it's not worse no.

R: It's not worse.

And is it an achy pain?:?
Is it something that is kind of <always> always there?, Does it come and go::?,
(0.2)
(0.5)
(1.1)
P: Mine is always there.
(0.5)
R: It's always there.
(.)
Okay.=

P: =Always there.=
R: =But yer not having any of the nerve symptoms down your legs anymore.
(1.0)
P: Neuro symptom symptoms I-I-
(0.6)
I-ah- may be a bit but no i-is at least it is not growing. My- it is not more.
(0.6)
R: =Okay.=

Sequence 10
Clip: C8P2 RP D VN LL 358-433
P: January?
(.)
or
(0.4)
#Februa[y#].
R: [ I ] ↑ think it ↓ should be February actually. But you know [ I jus: ].
P: [I think we did (cover)<] ( ).
(1.8)
R: Here's Februa[ry ].
P: [It's some]where.
[It's there].
R: [ Okay ]. Perfect.
(0.7)
Okay s:o: it looks like i-i-the pain really hasn't changed. And we've kind of had a chance to talk about that.
•hhh So it's changed i-i-it sounds like it's improved.
(0.6)
P: It sounds like ah[::::: i- ]=
R: [It's just t-]
P: =it doesn't it doesn't Press more on my nerves.
So that's wa:: what I'm::::[:]
R: [0]Kay=
P: =happy about I hafta •hh=
R: =Right.
P: C(h)u(h)z •hh it was ah:: it was °you know°.
(0.4)
(0.7)
R: So you feel like you're better able to manage the pain now?
(0.2)
P: Um:
(0.4)
R: Your everyday life is less affected by the pain?
(1.0)
P: Right now it's less.
(0.5)
R: It's less.
(0.4)
Okay.
(0.5)
So you're able to do activities that may be you weren't able to do before.
(1.0)
P: >Yeah-yeah-ah-: u:m< yeah.
(0.8)
*u:* We shall see yeah:
(0.3)
what happens: after because
(0.2)
this is not the end of the fight. No:::
(0.2)
R: No of course not.
(0.2)
P: I(hi-uh • hh
(0.2)
But: we shall see yeah.
(0.7)
R: *Okay*.
(0.7)
Um: and then one of the other
(0.5)
markers here was tired.

Sequence 11
Clip: C8P2 RP D VN LL 750-779
((P is off camera during this clip))
P: I can feel everythin but ah::: different.
(0.3)
R: Okay.
(0.9)
P: I(hu-hu) don(hh) know how [to explain ]
R: [And but you can't characterize it.
Like do you feel it LEss: or do you feel it mor::e
or does it feel ting:ly: or
(0.9)
prickly?
(1.1)
P: No:: it doesn't
(0.8)
Um: it does not prick ah:: prink ah:::
R: =Does it- it's not painful. 
(0.7)
P: Not painful: ah:: >but it is< different in some (respect). 
(.)
MAY BE A BIT More painful if you:: something like do something like this?, ah=
R: =Right. But not just normal touch. 
(0.3)
P: Not normal yeah. 
(0.7)
[No].
R: [O ]kay. 
(0.2)
Let's have yer shoes off if you don't mind.

Sequence 12
Clip: C8P4 SRP D A LL 124-193
R: Well wu::- regardless of what the CT scan shows us: it's looks like your symptoms are better. 
(0.6)
P: Yeah. [ I feel I feel less ]=
R: [It sounds like yer >symptoms are better<]. 
(0.4)
P: =pressure on my nerves. 
(0.4)
R: [Hm:::
P: [Cuz I ah]:: I was feelin all- 
(0.2)
more and more pressure. 
(0.4)
More and more pressure. 
(0.6)
R: That's great.=
P: =Especially at night I couldn't sleep well. 
(0.5)
R: Uh hm[:::
P: [Now] I can sleep wel- better 
(0.3)
at least better ah::: so, 
(0.7)
>This ( )< why I am thinkin that it- 
(.)
it's::: worked, 
(.)
some how. 
(0.3)
["Ah:::"]
R: [Uh hm:::
(0.6)
P: I don how far 
(0.3)
but ah::: 
(0.3)
yeah ah. 
(0.4)
SP: °pt° What does workeD
mean for you.

That the [radiation]

stopped pressing my nerves.

Ok[ay so ]

[Th-that] they're >>not more<<

stopped pressing my nerves.

Okay

least at least.

Ma[y be this it jus shrunk also.

pt Okay so you're hoping that at least it's not gotten

bigger and at best even that it might have shrunk.

I'm almost sure.

Uh huh.

pt *hh=

Yeah.=

Well radiation can do that, so we're hoping for that an:

we'll see.

Sequence 13

Clip: C8P4 SRP D A LL 604-644

[{Nobody] can tell me >where you< don't go !there,

!you don't go #ther:::e#. I go !where I !want_ (go from).

So° no problem?,

ARE You happy with where your pain control is now.

Or could it be better?,

/I th:ink #very yeah it's okay#.

pt You're SITting a <little> bit more comfortably.

May be because of the< radia(hh)tion.=

[I g(hh)]uess(h) *hh hh >Huh-huh-y(h)eah(h)<.

*hh hh
SP: Ideally we like to keep the pain three and below?

P: (Yeah)

SP: So if you need to use more oxycoset, you can.

P: (Oxy)coset the short acting one [I can ]

P: Uh huh.

SP: Okay.

Sequence 14

Clip: C8P4 SRP D A LL 645-747

P: MAY be you could prescribe me also=

SP: =Some more.

P: [•hhh ]

P: [>°Yeah yeah°<].

SP: AN:D-

a:-an::d

f::or: US:::

discomfort cou-

( .)

counts as much as <pain>.

P: [>Uh hm uh hm<]

SP: [Okay. So if you're uncomfortable or you're
g- uncomfortable sitting •hhhhhh

That counts as pain to me so

any BAD sensation that interferes with your sitting
your walking your standing,=

P: *pt•hhhh Ah

sometimes when I am:: ah:: for example lying down on my:
on my back for ah::: a long time

so:: ah::: my: right leg

ah:::

( .)

becomes

( .)
#ah:::::#

(0.2)

NUMb
(0.4)

may be ah=

SP: =Uh huh
(.

P: But not _completely but_ (1.2)
to _some degree_. •hhh
(.

Because ah:::
(0.8)
I think it's _something is:_
(0.2)
or: _what is ah::: the pressure_
it _jus pressin on nerves_.
(0.4)

SP: Uh hm:
(0.4)

P: That's ah:: why.
(0.3)
Yeah. •hhh At ah ((sniff))
(0.9)
pt when I _HAD RAdition_ the surface was _hard_.
(.

It also _depends on the surface_,
(0.6)
so I: _I had to:_
(0.3)
ah:::
(0.2)
lie down for _may be twenty minutes?_
(0.5)
so::: _my: right leg_ •hh ah:::
(0.4)

SP: Would go numb.
(.

P: Orth
(0.3)
y:eah: well huh::
(0.3)
going numb.
(0.3)

SP: pt •hhh [Now last time]
P: [>_I had to make SOME<] _exercises or something_
  like STretchin or I _did ah so it th-the joint was normal_
  position.
(1.0)
Yeah.
(0.2)
But NOW I _think it's a bit Less_.
(0.6)

SP: pt Okay so that's better.
(1.1)
P: Yeah hh.
(0.3)
SP: [•hnhh]
P: So:::=
SP: =LAst time we started the gabapentin. That was the medicine for the nerve pain. Have you been taking that as well?=
P: =Ah::: y:eah:: I'm taking some of but but not u:::m[:::
SP: [Cuz] we had asked you to [take you::] P: [not much ]

SP: th::ree times a da::y.

Sequence 15
Clip: C10P2 RP D VO LL 123-230
R: I was __comparing to the one (.)
to the one that you fill out today with the one prior. (0.7)
[An:dl]
P: [Yeah]
(0.3)
[ Yeah: ]
R: [And there] was a slight (li'l bit bit) of change.
[Not basically the pain but other (0.5)
other symptoms. observation (0.6)
The pain seems to be ah stable. (0.2)
P: [Yeah: ;more or less]
R: [ The same as °last] time°. (1.3)
What is the pain?
(1.2)
P: What?
(0.3)
P: [Where? ]
=Ah
(0.3)
it's usually in my pelvis and ah::: yeah it’s usually in my pelvis. (0.8)
So I have some like unusual feelin from the outer side
[of my legs]=
R: [ Uh huh ]
P: ="and my feet". (0.3)
R: °Uh hm°. •hh And when you say unusual is: it: is:=
=more painful or is (0.3)
feel dif[ferent]?,
P: [As in] feel different ah:::
(0.2)
not normal feelin, because here for example is everysing normal as it was before [the cancer].

R: Yeah:

P: But here it's:- it's: something like different.

R: Different?,

P: Yeah ah-ah usually I don't: feel it: when >I I< when it is not touched.

R: But when you touch it's different.

P: Both legs but more more the right one.

R: Especially the right.

And from one to ten when ten is the worst pain so you

P: Having: a tree.

R: Is that [correct]?

P: Yeah °yeah°.

R: How much oxycoset are you taking right now?

P: About six a day.
R: One to two a day?

P: "#Y:eah:: ah more or less yeah"#

R: And that's basically when you need to move in
order to some[thing (or when you sit)].

P: [ Or: to sit ]

for a long time [yeah].

R: [Okay].

Mainly when sitting.

P: When there is a pressure on my um:

P: on my [pelvis]

R: [ "Hm" ]

P: so that's

I have to take more.

R: Uh huh°.

R: Is any activity that you are avoiding to do
because of the pain?

P: Ah::

I am avoid-avoidin:::g may be

sitting for a long(h) ti(h)[me].

R: [Um] hm.

P: ["That's] about it°.

R: ["Okay° ]

P: Pressure on my pelvis >ah I'm< avoiding this.

R: Uh huh°.

P: I have to: sleep (all) usually on my::: stomach?,

R: Uh huh°.

P: I have to: sleep (all) usually on my::: stomach?

R: :Okay.

So:: it seems that the- the- the :day
the- the pain during the da::y has been stable.

Is that [correct]?

P: [Y:eah::]ah: it's it's more or less >yeah yeah<

stable ( ) during the night.

R: It's stable [more or less].

[ Uh huh ].
P: [There were] some cases before radiation that it was difficult for me to sleep at night.

R: Uh hm:

P: So what after radiation it seems to be better.

R: Okay.

P: Better.

R: Ca- can you remind me when did you have the radiation therapy?

Sequence 17
Clip: C10P2 RP D VO LL 890-947
((P is on the examining table to the side of the camera—only the side of his face is in view while he is doing the breathing and for a few of R's questions about his back pain. Then he sits back and is not visible to the camera for the remainder of the clip.))

R: I wanna listen to the back?

So the same. Breath in and out?

P: Hhhhh

R: [Okay ].

Thank you very much.

Is there any pain in your back,

right now?

P: **No**.

R: **No**.

P: **No**.

R: No.

P: No no **no**.

R: Here?,

(1.0)
No pain in the back.
(0.6)
So when you are sitting
(0.3)
is there any pain right now in pelvis in
[this area?, In the hip area?,]
P: [Yeah::: ah:::yeah there be]
a little pain. Yeah something like that "no".
(.,)
R: I'm gonna bend your legs
(0.3)
when you say that they=
P: [ Uh huh ]
R: =feels different.=
P: =>Uh huh<=
R: =So the first thing >that I'm gon<na::: do
(0.2)
is to raise your leg?

Sequence 18
Clip: C10P2 RP D VO LL 964-1033
((P is on the examining table out of view of the camera for the
duration of this clip))
R: It's a >little bit< swollen this one.=
P: =>Yeah yeah< it may be
(.
(0.8)
R: Is it new?
(0.7)
P: Ah:::::
(0.4)
I had ah:::
(0.5)
something like ah-
(0.6)
medication against nerve
(0.3)
nerve
(0.2)
nerve pain
(0.5)
a[:nd >it begin< m]ore
R: [ Gabapentin ]
(0.3)
More [of the]=
P: ["Yeah"].
R: =swellings [gon:e out of it?]
P: = [Ah more swelling] so I:::-
I discontinued it.
(0.7)
R: I-Is that the gabapentin?
(0.4)
P: I think yes.
(0.4)
R: W[hen whe-<]  
P: [ >I I< ] had da-da-d begins swu::  
[swelling swelling m]ore.  
R: [ Swollen less? ]  
(0.4)  
Oh ok[a:y].  
P: [So::: ↓I::: ↓I::: dis, continued it.  
I'll tell doctor (name) about this.  
(0.3)  
R: When did you ___ stop the medication__,  
(0.6)  
P: About a week ago.=  
R: =A week ago?,  
(0.3)  
And the main reason was because of the swelling:  
(0.2)  
[legs].  
P: [>Yeah yeah yeah<].=  
R: =Okay.  
(0.6)  
So we will< discuss that.  
•hh And how is the ↑pain ↓now:.  
Is::: ah::: is::: that  
[Bothersome >after you stop it<].  
P: [Ah it's more or less okay ] ah::: more  
[or less]  
R: [Any ↓ch]ang[es]?  
P: [No].  
(0.8)  
°No chan[ges] right now°.  
R: [Hm ]  
(0.4)  
pt U:::m: would you able to lie down here so I check i-the  
(0.2)  
s:::ensory?

Sequence 19

Clip: C17P2 RP Da VO LL 313-401  
((Only P is on camera. None of R is visible. This makes it  
difficult to definitively determine gaze.))  
R: So it looks like an-  
(0.6)  
so everything else um on the score is about the same as it  
wha-was what it was last time.  
(0.3)  
P: Yeah more or less [yeah].  
R: [Yeah].  
(0.4)  
So that's good.  
(,)  
•hhh U:::m:  
(0.4)  
pt  
(0.2)  
an:::d
(2.3)
>are you-do you have any pain<?
(0.9)
P: Ah:::
(0.3)
y:eah:: I have some pain ah:: yeah: usually in my pelvis.
(0.7)
R: Yeah.
(0.2)
P: Yeah.=
R: =Okay.=
P: °°There's ah°°
(1.6)
Sometimes I have a bit a little bit of here sometimes
but no:t ah: it is not:
(0.4)
°you know° sometimes only.
(0.9)
R: Okay. Is >that<, [a new ] pain?
P: >Usually<.
(0.4)
P: Ah?
(.
R: Is that a >new pain<?
(0.7)
P: Ah:::
(1.3)
may be it is not a new pain no. Because I have also
tumour here.
(0.3)
R: Yeah.
(0.4)
P: So:
(.
that's why sometimes I::: but °hm:::
(0.7)
right now it is not serious °or something like no°.
(0.3)
R: Okay.
(0.4)
U::m:
(0.2)
do you >feel it< occasionally you said.
(.
P: [ Occasionally ].
R: [When when when] do you notice it.
(0.9)
P: When?: I always notice it.
(0.7)
R: It's alwa- [you always]=
P: [ Always ]
R: =feel it there.
(0.2)
P: Y:eah:: sometimes yeah but °ah::
R: [Okay].
(0.5)
P: °°jus°°
R: Does anything make it better?

P: I don't need anything for this. Cuz I usually take oxycon.
R: [If you're not comfortable] with the level of pain we can
(0.2)
we can: [work (to-) for a bit].
(0.2)

P: [ Wa:: ah:: it's]:: yeah right now I-I-I:: can ta- [I can stand this].
(0.4)
We shall see.
(0.7)
R: °Okay°.
(0.4)
•hh U:::m::
°okay°.
(2.5)
°okay°.
(0.6)
And how are other things like your sleep?

Sequence 21
Clip: C17P2 RP Da VO LL 555-610
((Only P is on camera. None of R is visible. This makes it difficult to definitively determine gaze.))
P: Y:eah: there was a period that ah: before ah: I was sent to the radiation that ah: I had problems with sleepin.=
R: =Uh hm
(0.6)
P: But tha-ah it seems that after radiation it seems: to be improved
(0.3)
[so]
R: [Good].
(1.0)
P: °ah:°
(0.7)
R: [ An:::d ]
P: [Right now it's] more or less okay
(0.3)
R: °Okay°.
P: [ah right now].
(0.2)
R: Okay.
(0.2)
Good.
(0.7)
°An:::d° |do you ever wake from
(0.5)
u:m:
(.)
wake in the middle of the night because of pain?
(1.0)
P: Mn::: no.
(0.2)
R: No. °°Okay°°
P: [ No: ] not right now

334
(0.2)
no. Bu-but ↑there ↓wa-
(0.3)
before the radiation ye[s: ].
R: [Yeah].
(0.3)
Okay.=
P: =I had to [do this::].
R: [ "Okay" ].
(1.0)
R: °Good°.
(0.4)
An::d [are your ]
P: [They were] pressing on my nerves
[so really] it was.
R: [ <Yeah> ]
(0.6)
R: °And ↑are your bowels moving?°

**Sequence 22**

**Clip: C17P2 RP Da VO LL 735-760**

R: Yeah.
(0.7)
She thought you might be limping a bit more.
(1.7)
P: I don't think so.=
R: =No? (0.3)
Okay°.
(0.2)
P: °hm°°
(1.0)
R: Your pain is the same. (0.2)
P: The same ]
R: [Weakness an[pain ]
P: [>more or less<] the same.=
R: =Yeah.
(0.5)
[Okay]
P: [I think] °the same yeah°.=
R: =Okay.
(0.5)
And you're not-
(0.4)
you're a-not having new weakness in your legs.

**Sequence 23**

**Clip: C17P2 RP Da VO LL 954-987**

((Both P and R are off camera))

R: And now kick your leg-
(.)
push your leg out.
(1.9) Okay.

(0.3) and this side.

(1.9) Okay.

(0.4) Good. pt •hhh
And do you wanna lie down and I'll feel your belly?

(6.5)
°Good°

(1.4) °

(0.3) Any pains?

(1.2)

P: No.

(0.4) °Not right now°.

(0.7)

R: Big breath in?

P: =•hhh ↑•hhh

(0.4)

R: °Good°.

(0.3)

P: HHHhh

(4.6)

R: All right good.

(0.6)

Can you sit up?

Sequence 24

Clip: C17P2 RP DA VO LL 1068-1139

((Both P and R are off camera))

R: Let me just-

(0.3)

ah::: feel your back.

(1.0)

P: [I have the]=

R: [{ ______ }]

P: =hardware here you know. [ •HHH ]

R: [↑Oh ↑right]. Oh yeah.=

P: =Yeah yeah °(may be)°=

R: =Okay.

(0.7)

↑Any any °new pains in the back here?

(0.2)

P: New?

(0.2)

N:::o: n[°new].

R: [Yeah ].

(0.5)

P: °N[°no°]

R: [ Okay].
R: Where does it hurt the most in your back.
(0.5)
Or [in your pelvis].
P: [In my back] it's usually not. It's like °ah° pelvis ah:::
(0.2)
more here from the right [side].
R: [Yeah].
(0.6)
Ye[ah:: ].
P: [But it] is I also have here. But it is th-the right side is ah bigger.
(0.3)
R: Okay.
(0.3)
O:kay.
(0.2)
P: So.
(0.6)
R: pt *hhh All right.
(1.0)
*hhh And do you have any u::m:
(0.3)
aches-
(.)
having any numbness or u:m:
(0.2)
*hh in the:: u:m
(0.2)
pt the genital or the anal region?
(1.0)
Like >if if< you: if you're wiping with toilet paper?
Do you not-
(7.)
do you feel?
(0.3)
Does it feel normal?=
P: =I I feel ;but it is not may be normal but I still feel.
(0.4)
[ So ] °#ah::#:=
R: [Okay].
=SO everything kinda a little reduced.
(0.2)
P: Ah:::
(0.8)
R: Sensation wise.
(0.2)
P: >Yeah yeah< the sensation is different °is° some
I would say different.

Sequence 25
C17P4 LL 1394-1406
SP: *hh ↑O;kay
(.)
and you're sitting comfortably ah:: when we saw (patient's name)
earlier th- •hh ;you ;could tell when you were ;in ;pain because you'd sorta be si-sitting on your <side> a bit.
(0.2)
P:  ;Ah w:hen ah:: ;[so]me;times=
R:                [Hm]
(0.3)
P:  =when I'm ;doing ;this "most times yeah".
(0.2)
SP:  *hhh °Alright°. And your bowels are ;o; kay

Patient Topicalizes Pain – No Physician Information Seeking

Sequence 26
Clip:  C6P2(4) SRP DC VT LL 822-875
SP:  I talked to (name) at the chemo clinic?, (0.6)
P:   [(name)].
SP:  [i-] (0.3)
Yeah. Because u::m:: I couldn't see it in the system, so he's gonna re-fax the:: (0.6)
ah requisition for your CT. (0.3)
And doctor (name) did order it from here to here. (0.3)
(0.2)
So you're- including your pelvis. (0.2)
P:   Hm. (0.5)
SP:  Yeah. (.)
Cuz I >I had< left him a note last time at your chemo clinic. (0.3)
P:  Cuz that's all- ah I would say is that (0.5)
{( _ ) have pain
SP:  {(*(Pushes chair on floor in front of camera, camera moves, can no longer see P's face))*} (0.5)
P:   in my pelvis (0.2)
[ usu]ally
SP:  [sure] (0.5)
P:   °Ah° (0.9)
and I have it when I am sittin, (.) (0.9)
when there is pressure. Ah when I stand th- usually
almost no pain.=

SP: ((Nods head up and down quickly several times))
R: ={Uh huh.
   ((Nods head up and down quickly several times))
(0.9)
SP: Yeah. And the CT scan would
(.)
°n°-just help us know what's happening.
Whether the tumour's getting <smaller> or what's happening.
Hope;fully [ small ]
P: [I would] prefer
(1.1)
$to have it smaller$.

Sequence 27
Clip: C8P4 SRP D A LL 67-103
R: Okay.
(0.4)
•hhh Alright. So
(0.4)
u::m:: >and you know< one thing we kinda talked about
was that the radiation has <improved> u::m: your symptoms,
yer able to do more in the day.
(0.7)
P: I:: feel less pressure on my nerves.
(0.2)
R: On your [ nerves ].
P: ["Yeah"].
(.
R: Okay.=
P: =I think it has stopped
(0.3)
the
(0.2)
[ ah ]
SP: ["Yeah"]
(0.4)
P: ah:::::
(0.7)
this Monday?
(0.6)
I:-I'll have a::::: result.
(0.3)
R: Uh hm:[[::]]
P: [I'll] know.
(1.2)
Ah::
(0.5)
the Past Monday?, #o::f this week ah:::::
I °don [know°]=
SP: ["hm°]
P: =fifteenth #I::::# had the CT scan.
Sequence 28
Clip: C8P4 SRP D A LL 1017-1060

R: >You have a very positive attitude.
(0.2)
[That's great.]

P: °Yeah°.
(0.3)

P: Very positive.
(0.4)

R: >Uh huh<
(0.3)

P: °It's okay that I was sent to radiation at least yeah:
(0.6)

R: Uh hm:

P: =very okay.
(0.6)

SP: pt Good.
(0.8)

R: Good.
(0.3)

P: °Yeah°.
(0.6)

SP: Yeah.
(0.2)

P: ONE [DAY] AT A TIME,

P: [ ]

SP: [AN]:D WE [HOPE FOR THE BEST.

R: [Yeah] [Exactly ].
(0.3)

P: Yeah yeah.
(0.8)
## Appendix E: Transcription Notation

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Name</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>[text]</td>
<td>Square brackets</td>
<td>Indicates the start and end points of overlapping speech</td>
</tr>
<tr>
<td>=</td>
<td>Equal sign</td>
<td>Indicates the break and subsequent continuation of a single utterance</td>
</tr>
<tr>
<td>(# of seconds)</td>
<td>Timed pause</td>
<td>A number in parenthesis indicates the time, in seconds, of a pause in speech</td>
</tr>
<tr>
<td>(. )</td>
<td>Micropause</td>
<td>A brief pause, usually less than 0.2 seconds</td>
</tr>
<tr>
<td>. or ↓</td>
<td>Period or down arrow</td>
<td>Indicates falling pitch or intonation</td>
</tr>
<tr>
<td>? or ↑</td>
<td>Question mark or up arrow</td>
<td>Indicates rising pitch or intonation</td>
</tr>
<tr>
<td>,</td>
<td>Comma</td>
<td>Indicates continuing intonation</td>
</tr>
<tr>
<td>?,</td>
<td>Question mark + comma</td>
<td>Indicates a rising pitch or intonation that is stronger than a comma but weaker than a question mark</td>
</tr>
<tr>
<td>-</td>
<td>Hyphen</td>
<td>Indicates an abrupt halt or interruption in utterance</td>
</tr>
<tr>
<td>&gt;text&lt;</td>
<td>Greater than/less than symbols</td>
<td>Indicates that the enclosed speech was delivered more rapidly than usual for the speaker</td>
</tr>
<tr>
<td>&lt;text&gt;</td>
<td>Less than/greater than symbols</td>
<td>Indicates that the enclosed speech was delivered more slowly than usual for the speaker</td>
</tr>
<tr>
<td>°text°</td>
<td>Degree symbol</td>
<td>Indicates whisper, reduced volume, or quiet speech</td>
</tr>
<tr>
<td>°°text°°</td>
<td>Double degree symbol</td>
<td>Indicates a very low whisper or very quiet speech</td>
</tr>
<tr>
<td>ALL CAPS</td>
<td>Capitalized text</td>
<td>Indicates shouted or increased volume in speech</td>
</tr>
<tr>
<td>underline</td>
<td>Underlined speech</td>
<td>Indicates the speaker is emphasizing or stressing the speech</td>
</tr>
<tr>
<td>::::</td>
<td>Colon or colons</td>
<td>Indicates prolongation of sound</td>
</tr>
<tr>
<td>(hhh)</td>
<td>Hs in parenthesis</td>
<td>Audible exhalation</td>
</tr>
<tr>
<td>· or (·hhh)</td>
<td>High dot</td>
<td>Audible inhalation</td>
</tr>
<tr>
<td>(text)</td>
<td>Parenthesis</td>
<td>Speech which is unclear or in doubt in the transcript</td>
</tr>
<tr>
<td>((italic text))</td>
<td>Double parenthesis</td>
<td>Annotation of non-verbal activity – scenic details</td>
</tr>
<tr>
<td>( )</td>
<td>Empty parenthesis</td>
<td>Something is being said but speech cannot be determined</td>
</tr>
<tr>
<td>{text}</td>
<td>Script brackets</td>
<td>Indicates action corresponding with speech in square brackets</td>
</tr>
<tr>
<td>$text$</td>
<td>Dollar signs</td>
<td>Indicates that the enclosed speech was delivered with a smiley voice</td>
</tr>
<tr>
<td>--------</td>
<td>--------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>pt</td>
<td>Lip smack</td>
<td>Often preceding an inbreath</td>
</tr>
<tr>
<td>Hah, heh, hoh</td>
<td>Laugh syllable</td>
<td>Closed and open position of laughter</td>
</tr>
</tbody>
</table>