Closing medical encounters: two physician practices and their implications for the expression of patients’ unstated concerns

Jeffrey D. Robinson*

Abstract

When patients visit primary-care physicians, they frequently have more than one concern. Patients’ first concerns are solicited by physicians at the beginnings of encounters. A challenge to health care is how to get patients’ additional concerns raised as topics of discussion. If patients’ additional concerns are addressed, it tends to occur at the end of encounters. Using the methodology of conversation analysis, this article identifies and describes the interactional organization of two physician-initiated communication practices that are used to negotiate the closure of the business of encounters and a transition into the activity of closing encounters themselves. These practices have different implications for the topicalization of patients’ additional concerns. © 2001 Elsevier Science Ltd. All rights reserved.

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Introduction

An examination of the structure of physician–patient communication, including the norms and rules of interaction itself, is one path to understanding and solving problems in health care. For example, Pomerantz (1984) examined how physicians can manage difficulties with taking patients’ medical histories, Heritage and Stivers (1999) examined how pediatricians can reduce parents’ expectations for antibiotics, and Beach and Dixson (2000) examined how physicians can employ empathy to improve diagnosis. This article examines two different structures of interaction involved in closing medical encounters and discusses their implications for a recurrent problem in health care: Patients are not always able to express their full agenda of concerns. The article begins by reviewing this problem and its relationship to closing encounters. The bulk of the article is devoted to describing the interactional organization of two physician-initiated communication practices that physicians and patients use to negotiate the closure of the business of encounters and the transition into the closing phase of encounters. The article concludes by discussing the implications of these practices for patients’ topicalization of unstated concerns.

Statement of the problem

When patients visit primary-care physicians, they often have more than one concern, including medical problems, requests for non-diagnostic services (e.g., prescriptions), and requests for information (Barsky, 1981; Stoeckle & Barsky, 1981; White, Levinson, & Roter, 1994; White, Rosson, Christensen, Hart, & Levinson, 1997). Even if patients have a single concern, it can be multifaceted, containing multiple biomedical and psychosocial components (Lipkin, Frankel, Beckman, Charon, & Fein, 1995). All of this is important because physicians’ knowledge of the full spectrum of patients’ concerns is vital not only to the accurate diagnosis and treatment of medical conditions, but to
the delivery of comprehensive and quality health care (Fisher, 1991; Larsson, Säljö, & Aronson, 1987; Lipkin et al., 1995; McWhinney, 1981, 1989; Mishler, 1984; Sankar, 1986; Todd, 1984, 1989). Thus, an important question for health care is: How do patients’ concerns get raised as topics for discussion?

The primary way that patients’ concerns get topicalized is when they are solicited by physicians at the beginnings of encounters, with questions such as “What can I do for you today?” (Bates, Bickley, & Hoekelman, 1995; Beckman & Frankel, 1984; Billings & Stoeckle, 1989; Byrne & Long, 1976; Greenberger & Hinthorn, 1993; Heath, 1981; Seidel, Ball, Dains, & Benedict, 1995; Swartz, 1998; Zoppi, 1997). However, these solicitations are routinely understood by patients, and treated by physicians, as solicitations of single concerns. Upon completion of patients’ presentations of their first concern, rather than continuing to solicit additional concerns, physicians frequently deal with the first concern, which includes progressing through the activities of history taking, physical examination, diagnosis, and treatment (Beckman & Frankel, 1984; Beckman, Frankel, & Darnley, 1985; Marvel, Epstein, Flowers, & Beckman, 1999). This raises the question: How do patients’ additional concerns get topicalized?

There are at least two types of barriers to the goal of topicalizing patients’ additional concerns. First, there are psychological barriers. Patients can be anxious or embarrassed about raising and talking about additional concerns, either due to their serious nature (Lipkin et al., 1995) or to their relatively non-serious nature, in the sense that patients can feel that non-serious concerns are trivial and/or that their topicalization is accountable (e.g., patients might fear being labeled a hypochondriac).

Second, there are interactional barriers — that is, barriers built into the organization of communication itself. Specifically, interactants do not raise topics randomly. Rather, there are orderly communication practices for introducing new topics (Button & Casey, 1984, 1985, 1988/1989; Scheglo & Sacks, 1973).

Important for the present article is a practice discussed by Scheglo & Sacks:

A further feature of the organization of topic talk seems to involve “fitting” as a preferred procedure. That is, it appears that a preferred way of getting [topics] mentioned is to employ the resources of the local organization of utterances in the course of the conversation. That involves holding off the mention of a [topic] until it can “occur naturally,” that is, until it can be fitted to another conversationalist’s prior utterance, allowing his utterance to serve as a sufficient source for the mentioning of the [topic] (p. 301).

Scheglo & Sacks observed that there is “no guarantee that the course of the conversation will provide the occasion for any particular mentionable to ‘come up naturally’” and “[t]his is so even when the occasion for the conversation was arranged in the interests of that topic” (Scheglo & Sacks, 1973, p. 302). Thus, even in the context of physician–patient encounters, there is no guarantee that the interaction will provide a “natural” environment for the topicalization of patients’ additional concerns. This dilemma is compounded by the phase organization of encounters. Encounters are routinely composed of six activities: (1) relating to patients (i.e., opening encounters), (2) discovering patients’ reasons for attendance (i.e., physicians soliciting, and patients presenting, medical business or chief complaints), (3) conducting verbal and/or physical examinations (i.e., information-gathering investigations), (4) considering patients’ conditions (i.e., diagnosis), (5) detailing treatment or further investigation, and (6) terminating (i.e., closing encounters) (Byrne and Long, 1976). During the course of dealing with (i.e., diagnosing and treating) patients’ first concerns, the topicalization of additional, new concerns may be specifically non-relevant (Robinson, 1999). Furthermore, upon completion of dealing with patients’ first concerns, it can be relevant to end, or close, encounters (Heath, 1986).

These barriers have promoted the classic “by-the-way” syndrome (Byrne & Long, 1976), where patients present “doorknob” concerns. As Zoppi (1997) elaborated, “When the physician’s hand is on the doorknob, ready to exit, patients may have one or more important unresolved concerns that they want to discuss” (p. 51). This phenomenon appears to be quite general. White et al. (1994) found that patients raised new concerns in the closing phase of 21% of encounters. Thus, it appears that if patients topicalize additional concerns, one primary location is during the transition out of the business of encounters and into the activity of closing.

In order to solicit the full spectrum of patients’ concerns, physicians are trained to “survey concerns,” or solicit additional concerns throughout encounters (Cohen-Cole, 1991; Roter & Hall, 1992; Seidel et al., 1995; Swartz, 1998). Although physicians are encouraged to survey concerns after patients finish presenting their first concern (Lipkin et al., 1995), this rarely occurs (Beckman & Frankel, 1984; Beckman et al., 1985; Marvel et al., 1999). In practice, if physicians solicit additional concerns, they tend to do so after dealing with patients’ first concerns (White et al., 1994, 1997). Thus, analogous to patients, if physicians seek to topicalize patients’ additional concerns, one primary location is during the transition out of the business of encounters and into the activity of closing.
Despite the fact that this transition appears to be a critical locus for the negotiation of the topicalization of patients’ additional concerns, it has received extremely little analytic attention. In his groundbreaking analysis of videotapes of closings in British encounters, Heath (1986) focused primarily on the “series of moves through which the face-to-face orientation is dismantled, and mutually coordinated interaction is brought to an end” (p. 129). Although Heath was fully aware that “ending the consultation entails bringing the business to a satisfactory conclusion” (p. 129), the rigorous detail with which he analyzed the activity of closing itself allowed him only a brief discussion of how physicians and patients negotiate the transition from the business of encounters into the activity of closing. This transition was studied (albeit with a different methodology and analytic goal) by White and her colleagues (White et al., 1994, 1997). White et al., analyzed audiotapes of American encounters and focused on how physicians and patients communicate a “transition from the educational phase to closure.” White et al.’s research has been both pioneering and productive. For example, they demonstrated that the frequency with which patients topicalize new concerns is negatively associated with certain physician communication behaviors, such as giving patients information about the therapeutic regimen (White et al., 1994). The primary limitation of White et al.’s research is its reliance on audiotape data, which hampered their ability to operationalize and locate sentences that accomplished a transition into closing. Because they did not have access to physicians’ and patients’ closing-relevant, embodied actions as evidence for what constituted transition-relevant sentences, they relied on coders’ assessments of the talk. Coders’ exact agreement was only 50% (White et al., 1994).

This article identifies, and describes the interactional organization of, two practices that physicians and patients use to negotiate a transition from the business of encounters to the activity of closing. In order to do this, a brief review of the literature on closing interactions is necessary.

Closing interactions

The goal of closing medical encounters is verbally and nonverbally ending a spate of interaction between physicians and patients. However, physicians and patients cannot appropriately end encounters simply by stopping talking or walking out of the office. Communication during encounters is organized by a turn-taking system (Sacks, Schegloff, & Jefferson, 1974). As long as the rules for turn taking are operative, the possible completion of a turn of talk is a place where turn transfer is relevant (Sacks et al., 1974). Thus, the action of stopping talking or physically leaving the interaction is accountable (Schegloff & Sacks, 1973). That is, without additional work, post-turn silences will be understood as the product of one participant “declining” to speak and thus as a silence within a continuing encounter rather than as constituting the “end” of the encounter. In order to appropriately end encounters, physicians and patients must collaboratively work to suspend the transition relevance of possible turn completion such that stopping talking or leaving is understood as ending the encounter. According to Schegloff & Sacks (1973), a standard solution to this problem is a sequence of talk specialized for this particular job, called the “terminal” sequence, as seen in Extract 1:

**Extract 1: TERMINAL SEQUENCE**

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01 Terminal sequence --> A: Bye bye
02 Terminal sequence --> B: Bye
03 ((interaction ends))
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The first part of the terminal sequence (line 1) proposes closure of the interaction, obligates a second closing token from the recipient (line 2), and communicates that, upon completion of such a response, the interaction will end and the rules for turn taking will no longer be operative.

However, there are at least two reasons why a terminal sequence is not sufficient to appropriately close an interaction. First, initiating the first part of a terminal sequence (e.g., “Bye”) is not necessarily, by itself or in isolation, understandable as doing the action of proposing closure. For example, a patient who says “Bye” after a physician has completed history taking but before the physician has performed a physical examination would not be heard as seriously proposing closure but perhaps as “joking” and/or making some commentary on the anticipated pain of the exam. In order to get “Bye” heard as seriously proposing closure, participants must establish a warrant for proposing closure (Schegloff & Sacks, 1973), or an interactional environment in which the proposal of closure can be understood as such. Second, at any point during an encounter, physicians or patients may have additional topics to discuss that have not yet been introduced. The action of proposing closure of an interaction (e.g., “Bye”) threatens to interfere with participants’ as-of-yet unspoken agendas and thus infringe upon their rights to produce further talk and topicalize those agendas (Schegloff & Sacks, 1973). According to Schegloff and
Sacks, a standard, simultaneous solution to both of these problems is the “possible preclosing” sequence, as seen in Extract 2.

Extract 2: PRECLOSING SEQUENCE

01 Preclosing sequence -> A: Okay
02 Preclosing sequence -> B: Okay
03 Terminal sequence -> A: Bye bye
04 Terminal sequence -> B: Bye

A’s initial preclosing token (line 1) simultaneously proposes a warrant for closing the interaction and provides B with the opportunity to topicalize as-of-yet unspoken agendas. B’s responsive preclosing token (line 2) accepts and establishes a warrant for closing the interaction.

Important for the present article, practices for establishing warrants for closing interactions (e.g., producing a preclosing token, such as “Okay”), themselves face the problem of not necessarily, by themselves or in isolation, being understandable as such. For example, after the completion of history taking, a physician’s “Okay” is not likely to communicate a warrant for closure, but rather a likely shift to a new activity, such as physical examination (Beach, 1995b).

Participants must create an interactional environment in which warrants for proposing closure can be understood as such (Schegloff & Sacks, 1973). These can be called “closing-relevant” environments. Closing-relevant environments are largely determined by the organization of topics within conversations (Schegloff & Sacks, 1973). Specifically, some topics are understandable as “possibly last” topics of interactions and their completion can constitute closing-relevant environments. In medical encounters, due to the institutionalized ordering of activities (Byrne & Long, 1976; Waitzkin, 1991), the completion of treatment-related topics and actions — such as educating patients about treatment, writing prescriptions, and filling out insurance and laboratory test forms — can constitute closing-relevant environments (Heath, 1986; Robinson, 1999).

In addition to “possibly last” topics, there can also be “designedly last” topics, which are hearable as a last topic of an entire interaction and thus can communicate that the completion of the topic will constitute a closing-relevant environment. For example, it has been widely documented that, in both mundane and institutional contexts, the general action of arrangement making — especially when the arrangements invoke actions that will be accomplished after the current interaction is terminated — is socially understood as a last topic (Button, 1987; Hartford & Bardovi-Harlig, 1992; Heath, 1986; Houtkoop-Steenstra, 1987; Schegloff & Sacks, 1973; White et al., 1994).

This article analyzes two, physician-initiated communication practices that physicians and patients use to negotiate the closure of the business of encounters and the transition into the closing phase of encounters. These practices are deployed in closing-relevant environments and are organized into sequences of talk. Thus, they will be referred to as business-preclosing sequences.

Data and method

The data are drawn from a corpus of 48 audio- and videotaped adult, primary-care encounters collected from seven, community-based, Southern California practices between 1995–1998. Participants included an availability sample of one physician from each practice (four men and three women) and 48 of their patients (an average of seven patients per physician). All data collection was approved by a university human-subjects’ protection committee. Participants provided informed consent to be recorded prior to the study, were aware of being recorded, and gave permission to publish the recordings. All data were transcribed by the author (see The appendix for transcription conventions). The method used is conversation analysis (CA; for review, see Atkinson & Heritage, 1984), particularly as it is applied to the study of institutional interaction (for review, see Drew & Heritage, 1992). CA uses audio- and video-tapes of naturally occurring conduct to inductively describe the norms and rules of interaction; this includes a description of the procedures by which people produce their own behavior and understand and deal with the behavior of others. For example, researchers have examined how people build and coordinate turns of talk (Sacks et al., 1974), repair problems of speaking, hearing, and understanding (Schegloff, Jefferson, & Sacks, 1977), and build actions (e.g., offers, requests, assessments) and activities (e.g., opening and closing interactions) (Schegloff, 1968, 1995, 1996).

Analysis

The “arrangement-related” business-preclosing sequence

The first practice will be referred to as the “arrangement-related” business-preclosing sequence...
The arrangement sequence is typically composed of two sequences of talk and is schematically represented in Diagram 1.

The first sequence (la and lb) is called the future-arrangement sequence. In the first part of this sequence (la), physicians invoke an action that will be accomplished after the current encounter is terminated. Typically, these actions involve future arrangements that are particularized to the context of medicine. For instance, physicians can initiate instructions or proposals concerning when patients are to visit physicians next, such as “I’ll see you again in a couple of months” or “Come and see me at the end of next week.” Alternatively, physicians can initiate announcements of events that will or should occur after the encounter ends, such as “They’ll contact you with the appointment for the dermatologist” or “The nurse will be in a minute with a flu shot.” Similar to arrangements in mundane interaction, physicians’ future arrangements initiate designedly last topics and thus communicate that their resolution will constitute a closing-relevant environment.

The future-arrangement sequence deals primarily with securing patients’ acceptances of an arrangement. The first part of this sequence obligates either an acceptance or rejection of the proposed arrangement, and this is what the second part of the future-arrangement sequence (lb) is composed of. Patients routinely respond with tokens such as “Okay” or “Alright.” These responses simultaneously accept physicians’ arrangements, close the future-arrangement sequence, and collaborate in the creation of a closing-relevant environment.

Upon patients’ acceptances of the future-arrangement sequence, physicians frequently initiate a second, topic-closing sequence (2a and 2b; re: topic-closing sequences, see Davidson, 1978; Schegloff & Sacks, 1973). In the first part of this sequence (2a), physicians produce tokens such as “Okay?” and “Alright?”, typically with rising intonation. These tokens request reconfirmation of patients’ prior acceptances of physicians’ arrangements. These tokens obligate a response (2b) and provide patients with an opportunity to raise issues dealing with the particularities of physicians’ arrangements and patients’ prior acceptances of them. Insofar as physicians’ requests for reconfirmation (2a) markedly propose to close a designedly last topic (i.e., the future arrangement), and insofar as they are produced in closing-relevant environments, they strongly project a contingent shift into the activity of closing — that is, contingent upon patients’ confirmations. Patients routinely respond by confirming their acceptance with tokens such as “Okay” or “Alright.” When patients provide confirmations, they collaborate in closing a designedly last topic and establishing an environment in which closing the encounter is the most relevant next activity.

Two examples are provided of the arrangement sequence. First, see Extract 3. The patient is visiting the physician to monitor two chronic problems (blood sugar and blood pressure) and to deal with one new problem (extremely dry skin). At the end of the visit, the physician fills out a variety of forms, the last of which is for a referral to a dermatologist for her skin problem. Note that by saying, “An’ then, (0.9) one more form” (line 724), the physician indicates that the form for the dermatologist will be the last and thus that its completion will constitute a closing-relevant environment (Heath, 1986).

While the physician fills out the form for the dermatologist, the patient tells a story about buying wormy fish at a local supermarket. After the physician finishes filling out the form, he picks it up and confirms

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1 This is supported by White, Levinson, and Roter (1994), who found that two of the most frequent communication behaviors associated with transitions into closings were “clarifying the plan of care” and “orienting patients to specific next steps of the visit.” For example, White et al. cited sentences such as “Okay, let’s see you back in four or five months,” “If it’s not getting better in a week, let me know,” and “We’ll just see how it goes in the future” (p. 25).

2 Sequentially, the topic-closing sequence is a post-expansion sequence (Schegloff, 1995) to the future-arrangement sequence; it continues and finalizes the course of action of making the arrangement.
Extract 3: CRACKING HANDS (1,515.2)

724 DOC: An' then, (0.9) one more form.
725 (0.5)
726 DOC: For the dermatologist.

((129 lines omitted - patient tells a story about buying wormy fish while physician fills out dermatology form))

856 1a- DOC: ’hhh They’ll contact you. uh: with the
857 appointment for the dermatologist.
858 (.)
859 1b-> PAT: Okay.
860 1a-> DOC: Should hear within a couple weeks.
861 1b-> PAT: Alright.
862 2a-> DOC: Okay,
863 2b-> PAT: Uh [huh,
864 DOC: [I’ll see you again in a month.
865 PAT: Okay.
866 DOC: [Get a sugar again before- right be[forehand.
867 PAT: [Yeah I- well I
868 PAT: better remember to take the- (. ) this thing
869 back. I didn’t last time.
870 DOC: 0(h)k(h)ay.
871 (3.4)
872 DOC: Bye now.
873 PAT: Bye.
For a second example of the arrangement sequence, see Extract 4. The patient’s primary reason for visiting the physician is to follow up on a sinus infection. After concluding this business, they proceed to deal with three secondary pieces of business: reviewing an EKG, evaluating a chest x-ray, and discussing the patient’s cholesterol level. The first two are dealt with at lines 89–95. The physician initiates the third piece of business by saying, “Then: the only thing that you’re working on is your cholesterol” (lines 109–110). The physician’s characterization, “only thing,” and shift to future business, “working on,” communicate that cholesterol is a possibly last topic, the completion of which can constitute a closing-relevant environment. The physician concludes the topic of cholesterol by formulating an upshot of the prior discussion and summarizing a plan of care: “So we’ll give this a few months and see how you do.” (line 144; re: summaries and upshots as topic-closing devices, see Button, 1987). At line 146 (la →), the physician initiates an arrangement sequence by proposing a future-arrangement concerning when the patient will next visit the physician: “an’ then we’ll see you about Ma:rch.”

The patient accepts the physician’s proposal concerning the timing of the next visit, “(Uh) Okay” (lb →; line 148), and thus collaborates in the closure of a designedly last topic. Upon completion of the patient’s “(Uh) Okay,” the physician’s gaze and body are oriented toward the patient. After the patient accepts the proposal, the physician seeks to reconfirm the patient’s acceptance: “O:’Kay” (2a →; line 150). The physician’s “O:’Kay” is a bid to close the topic of the arrangement, which was itself positioned in a closing-relevant environment and thus projects a contingent shift into the activity of closing (Davidson, 1978; Schegloff & Sacks, 1973). This is supported by visual evidence. The patient is sitting on the edge of the bed and the physician is standing next to the patient. As the physician initiates “O:’Kay,” she begins to turn her body and gaze away from the patient toward a counter on the opposite side of the room, which communicates that she is removing her attention from the patient and making a transition into a new activity, most likely closing (Goodwin, 1981; Goodwin & Goodwin, 1987; Kendon, 1990a, 1990b, 1990c; Schegloff, 1998). The patient responds by confirming his acceptance, “N:ot a ’pro’blem” (2b →; leaving, thereby producing relatively extended closings. One important point is that talk is typically understood relative to the courses of action and activity in which it is embedded (Schegloff & Sacks, 1973). For example, in Extract 3, after the patient has begun to both reconfirm her acceptance of the physician’s arrangement (line 863) and stand up, the physician says, “I’ll see you again in a month” (line 864). Although this is a proposal of a future arrangement to be confirmed or disconfirmed (which the patient confirms at line 865, “Okay”), it is produced in the context of the in-progress activity of closing and does not accomplish exactly the same action as the future-arrangement proposal discussed earlier—that is, those produced in the context of closing-relevant environments. For example, the physicians’ proposal at line 864 is neither produced nor understood to project a contingent shift into closing; rather, it is a “last minute” reminder. These observations drive home the imperative that, when coding communication, researchers be sensitive to the courses of action and activity in which it is embedded.

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Footnote 4 continued
line 151), which collaborates both in closing the arrangement and in the projected shift into the activity of closing. It was argued earlier that topic-closing sequences provide patients with a sequential opportunity to raise issues dealing with the particularities of physicians’ arrangements. This is supported by the patient’s “N:ot a ‘pro’blem,” which displays his orientation to the physician’s “O:‘kay” as seeking confirmation of the acceptability of the arrangement. Following the patient’s “N:ot a ‘pro’blem,” the physician continues to move toward the counter and produces “O:‘kay” (line 153), which initiates a shift to new matters (Beach, 1995a, 1995b), in this case the activity of closing. This is supported by the fact that, as the physician produces “O:‘kay,” she begins to close the patient’s medical records (which she has used throughout the encounter) and continues to move away from the patient. The physician’s “Su:re” (line 156) grants the patient permission to go ahead with his line of questioning, which he does at lines 157–161. The patient’s attempt to topicalize additional concerns is produced with reference to, and competitively with, the physician’s transition into closing and functions to interdict this activity. In Button’s (1987) terms, the patient re-opens the closing. This is supported by the patient’s use of the word “though” (line 155), which positions his proposed activity of asking “questions” as competing with an alternate activity, that of closing. The patient’s move to interrupt closing is a delicate matter after all, he and the physician had just collaborated in paving a road to closure. Indeed, as Schegloff (1980) found, telling someone that you have a question to ask them can be a way of communicating that the projected question concerns a “delicate” matter. The patient re-opens the closing in order to topicalize new concerns. However, if the arrangement sequence at lines 146–151 was, in fact, a practice for negotiating the closure of the business of the encounter and a transition into closing, then we should expect that, after the physician and patient finish discussing the patient’s additional concerns, then they should proceed to, once again, transition into closing. Indeed, after the topic of the cyst is closed, they close the encounter. Thus, there is evidence that the patient’s additional concerns are produced interruptively with, and as a “diversion” from, the activity of closing.
The physician’s summary of the diagnosis and treatment at lines 250–251, “Yeah it’s just a small little cyst that we’ll really wouldn’t do anything about it,” proposes to close the topic of the cyst (Button, 1987), and the patient collaborates with this by producing “Okay” (lines 253). Upon completion of the patient’s “Okay” (line 253), the physician is again standing in front of, and gazing at, the patient. At line 254, the physician asserts “So you’re all set,” which proposes to end the encounter and thus begins to negotiate a shift into the activity of closing. This is supported by the fact that, as she says this, she begins to shift her body and gaze away from the patient toward the door in preparation for exiting the room. These nonvocal behaviors are similar to those that the physician enacted during her initial shift into closing (line 150) and again communicate that she is removing her attention from the patient and making a transition into closing (Goodwin, 1981; Goodwin & Goodwin, 1987; Kendon, 1990a–c; Schegloff, 1998). There is evidence that the patient understands this. As he accepts the physician’s proposal, “Okay” (line 256), he begins to get off of the table in preparation for exiting the room.

In sum, the arrangement sequence is typically composed of two, ordered sequences of action: a proposal of a future-arrangement and a request for reconfirmation of patients’ acceptances. The future-arrangement sequence deals primarily with securing patients’ in-principle acceptance of the arrangement sequence and provides patients with a sequential opportunity to raise issues dealing with the particularities of physicians’ arrangements. The arrangement sequence is one communication practice that physicians and patients use to negotiate the closure of the business of encounters and a transition into the activity of closing.

The “final-concern” business-preclosing sequence

A second practice will be referred to as the “final-concern” business-preclosing sequence (hereafter, “final-concern sequence”). In its most basic form, the final-concern sequence consists of a single sequence of talk, and is schematically represented in Diagram 2.

In the first part of this sequence (la), physicians solicit “last” or “final” concerns, with questions such as “Any other problems?” or “Anything else?” These questions obligate either “yes”- or “no”-type answers (lb). “Yes”-type answers are ones that topicalize concerns (which do not have to be “new” relative to the prior encounter) and lead to their discussion. “No”-type answers are ones that decline to topicalize concerns and acquiesce to a shift into closing.

In principle, final-concern questions can be grammatically designed, and rhetorically delivered, in many different ways. For example, physicians can either ask “Do you have other concerns?” or “Any other concerns?” (Cohen-Cole, 1991). However, in practice, physicians’ final-concern questions are frequently designed with a bias such that they “prefer” “no”-type answers, or answers that decline to topicalize additional concerns and acquiesce to a shift into closing (re: the conversation-analytic conception of “preference,” see Heritage, 1984; Pomerantz, 1984; Sacks, 1987; Schegloff, 1988, 1995). One of the most common ways in which this bias is achieved is by including the negative polarity item “any” into the final-concern question (e.g., “Any other concerns?”; Bolinger, 1957; Cohen-Cole, 1991; Frankel, 1990; Quirk, Greenbaum, Leech, & Svartvik, 1985; White et al., 1994, 1997). This bias can also be achieved by using negative question formats (e.g., “You don’t have other concerns, do you?”). Another way is that physicians can ask final-concern questions with an “exasperated” tone of voice. Finally, physicians can ask final-concern questions while their gaze and body orientation nonverbally communicate that they are not (fully) engaged in interaction with patients and/or that they are more dominantly engaged in another activity. For example, physicians can ask while gazing at, and writing in, the medical records, or while they are in the process of standing up and preparing to leave the room. This is perhaps why one textbook encourages physicians to “ask the patient if there are questions or unfinished business before beginning to stand up” (Zoppi, 1997, p. 51, emphasis added).

Boyd and Heritage (forthcoming) found that, during the activity of history taking, physicians design questions according to the “principle of optimization” — that is, with a bias toward pro-social or pro-health (i.e., no-problem) outcomes. At least regarding final-concern questions, physicians appear to ascribe to this principle by designing them to prefer “no”-type answers.

Diagram 2. Two Trajectories of the Final-Concern Business Preclosing Sequence
however, for all of the benefits that “optimized” final-concern questions offer regarding saving patients’ face (Brown & Levinson, 1978), they can have the disadvantage of being heard as “perfunctory” or “not genuine.” The result is that, when physicians “optimize” final-concern questions, they interactively manipulate patients away from topicalizing additional concerns and toward closing encounters. In sum, if physicians want to maximize the potential of their final-concern questions for soliciting additional concerns, they should halt competing activities (e.g., writing in the medical records), orient their bodies and gaze toward patients, and grammatically design their questions so as not to prefer “no”-type responses (e.g., “Do you have other questions or concerns?” or “Are there other things that you wanted to address today?”).

What follows are two examples of the final-concern sequence. First, see Extract 5. The patient is visiting the physician for shoulder pain. The physician concludes that an X-ray is necessary and, at lines 342–347, discusses when and how he will contact the patient with the results. During the long silence at line 348, the physician writes a prescription for an anti-inflammatory medication. The completion of writing the prescription possibly completes the activity of treatment and thus constitutes a closing-relevant environment (Heath, 1986). At line 349, as the physician finishes writing the prescription, he asks a final-concern question, “‘Anything else?’” (la).

Extract 5: SHOULDER PAIN (1:166:6)

342 DOC: ‘hhs Uh if the ‘X’ ray is shows anything ba::d, (0.5)
343 I: will cr::ll.
344 PAT: Okay.
345 DOC: If I can’t reach you, (0.3) I’ll write you a lgtter.
346 (.)
347 PAT: Great.
348 (10.5) ((physician writes prescription))
349 1a-> DOC: 0Anything e:lse.0
350 (1.9)
351 1b-> PAT: ‘hnhnh No:: I don’t think so.==hhhhhhhh I’m doing
352 pretty well otherwise.
353 (1.4)
354 DOC: ‘mtch=’hh >By the way< if this bu::ns your stgmach
355 you should take it with foo::d_ you can take an
356 anta::c[id,]
357 PAT: [{Mm} hm]=
358 DOC: ‘=’hh [Something like] that.
359 PAT: [(What med is it)]
360 DOC: ‘h Indomethacin, (.) Indacine,
361 (.)
362 PAT: Okay.
363 DOC: ‘hhh (0.2) hhhh o‘Ka:y0
364 PAT: ( )
365 (0.8)
366 1a-> DOC: Any other questions.
367 (0.3)
368 1b-> PAT: No::,=>I just< wait to hea:r about the physical
369 therapy?
370 DOC: >Mm hm,< w’=you and thuh nurse can arrange
371 that right now.
372 PAT: (Okay.)
373 (0.7)
374 PAT: Thanks for getting me in so f[a:st. ]
375 DOC: [“Q”kay.]
376 (0.8)
377 DOC: We:(11) you know I had nothin’ to do with it. Thanks
378 my nurses.
379 PAT: Hehe hah huh huh huh huh.
380 PA?: (They do good) work. ‘hh huh=
If the physician’s “‘Anything else.’” (la; line 349) projects a contingent shift into the activity of closing — that is, contingent upon a “no”-type answer — then upon completion of the patient’s “no”-type response, “No:(b) I don’t think so. hhhhhhh I’m doing pretty well otherwise” (lb; lines 351–352), we would expect the physician to shift into closing. Initially, this is not what happens. Rather, the physician instructs the patient about what to do if the medicine burns her stomach (lines 354–356). However, there is evidence, in the design of the physician’s instruction, that his final-concern question did, in fact, project a contingent shift into closing. Specifically, the physician prefaced his instruction with “‘>By thuh way’” (line 354). According to Schegloff and Sacks (1973), this is an example of a “misplacement marker,” which display an orientation by their user to the proper sequential-organizational character of a particular place in a conversation, and a recognition that an utterance that is thereby prefaced may not fit, and that the recipient should not attempt to use this placement in understanding their occurrence (Schegloff & Sacks, 1973, p. 320).

With “‘>By thuh way’,” the physician communicates that his instruction is “misplaced,” or inconsistent, relative to the trajectory of the encounter established by prior talk, which was the final-concern sequence. The physician’s misplacement marker displays his orientation to producing his instruction within an environment where “proceeding to close” was the most relevant trajectory, and thus to the final-concern sequence as having established that trajectory.

If the physician’s instruction was misplaced relative to closing, then upon completion of the instruction, we should expect the physician to, once again, shift into closing, and this is what happens. The physician’s instruction to the patient is possibly complete when the patient agrees to comply with “‘Okay’” (line 362). The physician’s subsequent “‘Kay’” (line 363) communicates that he has completed his instruction and that he is about to shift to a new matter (Beach, 1995a, 1995b), in this case the activity of closing. There are two pieces of evidence to support this. First, as the physician produces “‘Kay’”, he places a carbon copy of the prescription slip into the patient’s records, which is preparatory to completing medical business. Second, the physician proceeds to ask a second final-concern question, “‘Any other questions’” (line 366). The fact that this question is functionally similar to the physician’s prior “‘Anything else.’” (line 349) is some evidence that his prior action of instructing the patient (lines 354–363) was an excursus from a shift into closing. In response, the patient ultimately produces a “yes”-type response by asking a question about the logistics of her treatment: “‘>I j’st wait to hear about thuh physical therapy?’” (lines 368–369).

If the physician’s “‘Any other questions’” (line 366) projected a contingent shift into closing, then we should expect that, after the patient’s question is answered, the physician and patient will shift into closing. This is supported by visual evidence. The patient is sitting on the edge of the bed and the physician is seated in a chair in front of the patient. After the physician answers the patient’s question (lines 370–371), and after the patient communicates that her question has been satisfactorily answered, “(Okay)” (line 372), the physician begins to stand up in preparation for exiting the room. In sum, upon resolution of the question-answer exchange, the physician displays his orientation to closing the encounter and thus to the patient’s question as being a “final” question. In this way, the physician displays his orientation to “‘Any other questions’ as soliciting “final” questions preliminary to shifting into the activity of closing.

For a second example of the final-concern sequence, see Extract 6. The patient’s primary concern is a mole on her neck. After dealing with this concern, the physician and patient proceed to deal with two secondary concerns: migraines and high blood pressure. After dealing with these concerns, the physician writes multiple prescriptions (lines 433–436). The patient’s “‘Kay, Thank you’” (line 452) is responsive to the physician handing her the prescription slip. The termination of the activity of prescription writing constitutes a closing-relevant environment (Heath, 1986). In this environment, the physician asks a final-concern question, “‘Anything else’” (la; line 454).

Extract 6:  NECK MOLE (1:166:1)

<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>381</td>
<td>DOC: =Okay.</td>
</tr>
<tr>
<td>382</td>
<td>(0.2)</td>
</tr>
<tr>
<td>383</td>
<td>PAT: =Bye.</td>
</tr>
</tbody>
</table>

((15 lines omitted - physician writes prescriptions))
In response to the physician’s “Anything else” (line 454), the patient produces a “yes”-type answer by beginning to ask a question about the future contingencies of her treatment: “Now shou(ld)- could you- if: this seems to be working...” (1b; lines 455–456). Before the patient finishes her question, the physician answers by offering to perform a blood test (to monitor potential negative side effects of the medication he just prescribed). The physician and patient proceed to discuss the blood test and the effects of different drugs (data not shown). At line 512, the physician is writing in the patient’s medical records, most likely documenting the blood test.

If the physician’s initial “Anything else” (line 454) communicated a contingent shift into closing — one that was not realized due to the patient’s question (455–456) — then we should expect that, upon completion of the discussion prompted by the patient’s question, they will once again move toward closing. Indeed, at line 513, the physician re-asks, “Anything else?” (la). At this point, the physician is still writing in the records. Because his gaze and body orientation communicate engagement with the activity of writing, and not with interacting with the patient, the physician literally embodies a preference for a “no”-type answer. The physician’s second “Anything else” (line 513) is a repeat of, and ties back to, his earlier “Anything else” (line 454), and this is additional evidence that the physician’s original “Anything else” was designed to project a contingent shift into closing.

Although the patient’s response, “Yeah just don’t move- (0.8) Just don’t leave here” (lb; lines 514–515) nominally constitutes a “yes”-type response (i.e., it is a request), it is designedly non-serious, as indicated by the patient’s laughter (lines 515 and 518), and does not raise additional concerns. There is visual evidence that the patient understands the physician’s “Anything else” (line 513) as communicating a contingent shift into closing. The patient is sitting on the edge of the bed and the physician is sitting in a chair in front of the patient. At the completion of her answer (line 515), the patient shifts her hands from being clasped in front of her in her lap to on top of her legs (palms down) in preparation for standing up, thereby displaying her orientation to a shift into closing. As the physician responds to the patient’s joking request with an equally non-serious answer, “I won’t. As long as there’s surf” (line 517; the physician’s office is one block away from the Pacific Ocean), both physician and patient begin to stand up in preparation for exiting the room.

In sum, the final-concern sequence consists of a single sequence of talk, which is initiated by physicians’ solicitations of last or final concerns. These solicitations allow patients the opportunity to provide either “yes”- or “no”-type answers, which either raise, or decline to raise, new concerns, respectively. Like the arrangement sequence, the final-business sequence allows physicians and patients to negotiate the closure of the business of encounters and a transition into the activity of closing.

Implications for the topicalization of patients’ additional concerns

The arrangement sequence and final-concern sequence have different implications for the topicalization of patients’ additional concerns. First, consider the arrangement sequence. As seen in Diagram 3, there are
essentially four “slots” in which patients can opt to topicalize new concerns.

The arrangement sequence does not provide patients with a formal opportunity to topicalize additional concerns. That is, physicians’ proposals of future arrangements obligate a specific type of response (in slot 1), that being an acceptance or rejection of the proposal. Thus, it is not initially relevant (in slot 1) for patients to respond by topicalizing new concerns. After accepting physicians’ proposals (i.e., at the end of slot 1), patients have the potential to relevantly topicalize new concerns. However, doing so at this point is problematized by two issues. First, the rules for turn taking (Sacks et al., 1974) stipulate that, after patients accept or reject physicians’ proposals, physicians (and not patients) have the right to speak next (in slot 2). Second, when patients accept physicians’ proposals (as their initial response in slot 1), they close a designedly last topic and collaborate in the creation of a closing-relevant environment. When physicians’ proposals of future arrangements are themselves already positioned in closing-relevant environments (as were all of the cases examined), patients’ acceptances collaborate in the first part of a transition out of the business of encounters and into the activity of closing. Thus, even if patients “want” to continue to topicalize new concerns (i.e., at the end of slot 1), they must do so in competition with the relevance of closing.

Similar to the future-arrangement sequence, the first parts of physicians’ topic-closing sequences (i.e., slot 2) obligate a specific type of response (in slot 3), that being patients’ reconfirmation or non-confirmation of their prior acceptances of physicians’ proposals of future arrangements. Thus, it is not initially relevant (in slot 3) for patients to topicalize new concerns. Admittedly, it may be relevant for patients to respond to physicians’ topic-closing utterances with questions about the particularities of the prior arrangement, but it is not relevant to initiate wholly new concerns (Houtkoop-Steenstra, 1987). This is supported by Heath (1986). In his data corpus of over one thousand British encounters, he found only three cases in which patients declined physicians’ proposals to end the business of encounters and transition into the activity of closing. Furthermore, Heath found that when physicians’ proposals are declined, “subsequent talk focuses on the earlier problem or related matters. There are no examples in the data corpus of the third possibility occurring, the introduction of a new topic, a different complaint, or whatever” (p. 142).

After confirming their acceptance (i.e., at the end of slot 3), patients have the potential to relevantly topicalize new concerns. However, this is again problematized by the two issues mentioned previously. First, the rules for turn taking (Sacks et al., 1974) allow physicians (not patients) first rights to speak after patients reconfirm their acceptance. Second, when patients reconfirm their acceptance (in slot 3), they collaborate in the creation of an environment in which closing is the most relevant next activity. Thus, more than before, even if patients “want” to continue to topicalize new concerns, they must do so in competition with closing. Perhaps this is why White et al. (1997) found that, in 18% of encounters, patients interrupted physicians’ attempts to close encounters by topicalizing new concerns.

In sum, the arrangement sequence does not provide patients with a formal opportunity to topicalize new concerns.

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4 In sequence-structural terms, in response to physicians’ proposals of future arrangements, patients have the right to produce one turn-constructional unit before turn transfer is relevant (Sacks et al., 1974). Patients’ acceptances or rejections typically constitute one turn-constructional unit. If patients want to topicalize new concerns after accepting or rejecting physicians’ proposals, they must do additional work to secure a response that contains more than one turn-constructional unit. There are a variety of communication practices for doing this (see Schegloff, 1987; Just, 1996).
concerns; that is, it does not provide patients with a sequential “slot” dedicated to the possibility of relevantly topicalizing new concerns. This is not to say that patients cannot topicalize new concerns. For instance, see Extract 7. The physician proposes a future arrangement at lines 123–124, which the patient accepts at line 125. The physician elaborates this proposal at line 126, which the patient again accepts at line 127. At line 128, when the physician says “Uh:m” he communicates that he will eventually produce a turn of talk and thus “holds” his turn of talk (Schegloff, 1996). During the extended silence at line 129, the physician gazes ahead of him and embodies a “thinking” position, which is another way that he holds his turn. After two seconds of silence, and in competition with the turn that the physician is holding, the patient topicalizes a new concern by asking, “Now do I have to have a vaginal t-uh examination?” (line 130).

For another example, return to Extract 4. The physician’s proposal of a future arrangement (line 146) is accepted by the patient (line 148) and the physicians’ request for reconfirmation (line 150) receives a confirmation by the patient (line 151). At line 153, the physician verbally and nonverbally begins to close the encounter. At just this point, the patient topicalizes new concerns (lines 154–155). However, just as in extract 7 (above), the patient does so (and, as analyzed earlier, orients to doing so) in competition with the activity of closing.

In sum, the arrangement sequence interactionally constrains patients away from topicalizing new concerns by simultaneously: (1) initiating a designedly last topic (i.e., making a future arrangement), the completion of which is tantamount to closing; and (2) not providing patients with a formal opportunity to topicalize additional concerns. If patients topicalize new concerns during the arrangement sequence, they must: (1) initiate that topicalization; (2) specifically work to do so; and (3) do so in competition with other, more relevant actions and activities related to closing encounters.

Extract 7: QUESTIONABLE CHANGE (1:515:4)

123 1a-> DOC: An::d=uh:m (2.1) then I'll s::ee you again maybe
124 in about (. ) three months,
125 1b-> PAT: Alright,
126 1a-> DOC: Which'd be (1.0) towards the end of January,
127 1b-> PAT: Mm hm,=
128 DOC: =Uh:m
129 (2.0)
130 *-> PAT: Now do I have to have a vaginal t-uh examination?
131 (3.0)
132 PAT: You said something about it last time.

The arrangement sequence differs markedly from the final-concern sequence. Although physicians’ final-concern questions, such as “Anything else?”, may verbally and/or non-verbally embody a preference for “no”-type answers, they nonetheless obligate an answer in terms of new concerns and provide patients with a formal opportunity to topicalize those concerns. And patients do capitalize on this opportunity. For example, as we saw in Extract 6 (above), in response to the physician’s, “Anything else?” (line 454), the patient asks a question about the future contingencies of her treatment (lines 455–456). For another example, see extract 8. The patient is visiting the physician to follow up on a condition of dizziness. In response to the physician’s, “Alright anything else?” (line 216), the patient ultimately initiates a new telling about her interaction with a psychologist (who she saw in between the last visit and the current visit).

Extract 8: DIZZINESS (1:166:8)

216 1a-> DOC: Alright anything glse.
217 (0.5)
218 1b-> PAT: Uh:m: (0.3) No otherwi:se I’m (. ) I- I’ m doing
219 1b-> pretty good.=I had a good old cry with that- n:yrse
220 1b-> an’ boy did it- I mean with the uh psychglogist
221 1b-> ‘hh sgemed to relieve me a lot.

This telling ultimately results in a discussion about a wide variety of both psychosocial concerns of the patient (e.g., not feeling completely comfortable with the psychologist) and biomedical concerns of the physician (e.g., the psychologist recommended that the patient see a psychiatrist in order to be prescribed anti-depressant medication).
Discussion

Quality health care depends on physicians knowing the full spectrum of patients’ concerns (Fisher, 1991; Larsson et al., 1987; Lipkin et al., 1995; McWhinney, 1981, 1989; Mishler, 1984; Sankar, 1986; Todd, 1984, 1989). Although physicians’ opening solicitations of patients’ concerns (e.g., “What can I do for you today?”) provide patients with a formal opportunity to present at least one of their concerns, this leaves open, and presents the problem of, how additional concerns will be topicalized. This problem is compounded by psychological and interactional barriers to the topicalization of additional concerns (Lipkin et al., 1995; Schegloff & Sacks, 1973; Zoppi, 1997). Perhaps the most relevant location for either physicians or patients to topicalize additional concerns is in closing-relevant environments where they begin to negotiate the closure of the business of encounters and a transition into the activity of closing (White et al., 1994, 1997). This article identified, and described the interactional organization of, two physician-initiated communication practices that are used to accomplish such negotiations: the arrangement sequence and the final-concern sequence. Although both of these practices project a contingent shift into the activity of closing, they have different implications for the topicalization of patients’ additional concerns. Specifically, the arrangement sequence does not provide patients with a formal opportunity to topicalize additional concerns, whereas the final-concern sequence does.

This article suggests that patients are more likely to topicalize additional concerns when physicians use the final-concern sequence. However, it was noted that physicians frequently verbally and non-verbally design final-concern questions in ways that interactionally manipulate patients toward responses that do not raise additional concerns. If physicians want to maximize the potential of their final-concern questions for soliciting additional concerns, they should halt competing activities (e.g., writing in the medical records), orient their bodies and gaze toward patients, and grammatically design their questions so as to not bias patients’ responses (e.g., “Do you have other questions or concerns?” or “Are there other things that you wanted to address today?”). One avenue for future research is the examination of whether or not different word choices — such as “Do you have other questions” versus “Do you have other concerns?” versus “Do you have other problems?” — have implications for patients’ responses.

Admittedly, the arrangement sequence and the final-concern sequence perform different functions, each of which are important. That is, physicians may need to both secure future arrangements with patients and solicit additional concerns. These two practices are not mutually exclusive and physicians can and do use them in combination.

Although this article examines two business-preclosing practices, it is likely that there are others. For example, there are other communication practices for markedly closing topics, such as: (1) producing “a proverbial or aphoristic formulation of conventional wisdom which can be heard as the ‘moral’ or ‘lesson’ of the topic” (Schegloff & Sacks, 1973, p. 306; see also Button, 1987); (2) producing a “figurative expression” (Drew & Holt, 1998); and (3) summarizing the upshot of a topic (Button, 1987). When these practices are used in closing-relevant environments to close possibly or designedly last topics, they can project a contingent shift into the activity of closing. Future research needs to investigate these practices and their implications for health care.

Acknowledgements

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Appendix

The following transcription conventions were developed by Jefferson (1984).

<table>
<thead>
<tr>
<th>Convention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC/PAT:</td>
<td>Speaker identification: Physician (DOC); patient (PAT).</td>
</tr>
<tr>
<td>[overlap]</td>
<td>Brackets: Onset and offset of overlapping talk.</td>
</tr>
<tr>
<td>=</td>
<td>Equal Sign: Utterances are latched or ran together, with no gap of silence.</td>
</tr>
<tr>
<td>–</td>
<td>Hyphen: Preceding sound is cut off / self-interrupted.</td>
</tr>
<tr>
<td>#word#</td>
<td>Number sign: Words/sounds are produced with a gravel voice.</td>
</tr>
<tr>
<td>£word£</td>
<td>British pound sign: Talk is produced while smiling.</td>
</tr>
<tr>
<td>↑ word ↓</td>
<td>Up arrow/Down arrow: Increased pitch relative to surrounding talk.</td>
</tr>
<tr>
<td>↓ word ↑</td>
<td>Down arrow/Up arrow: Decreased pitch relative to surrounding talk.</td>
</tr>
<tr>
<td>(0.0)</td>
<td>Timed Pause: Silence measured in seconds and tenths of seconds.</td>
</tr>
<tr>
<td>(.)</td>
<td>Parentheses with a period: A micropause of less than 0.2 seconds.</td>
</tr>
</tbody>
</table>
References


