Abstract Communication between patients and physicians is currently a significant topic in medical training programmes and in research on clinical practice. Physicians are encouraged, for example, to attend to patients' stories as ways of providing their concerns and understandings of their illnesses. However, there is little research on how storytelling is actually accomplished in the context of clinical encounters. Drawing on studies of medical discourse, conversational storytelling, and narrative, we present a comparative analysis of two encounters. Both revolve around the same clinical tasks, but in one the patient’s story is prominent and in the other it is unheard. We follow the course of successful storytelling in one and its interruption in the other, showing how the encounters unfold through patients’ attempts to negotiate a story topic, set the scene, and clarify the action and its consequences. The physicians adopt distinctive alignments with respect to the emerging story. These differences appear to be related to the outcomes of the encounters, including the framing of clinical decisions and the maintenance of cooperative patient-physician relationships. Focusing on the patients' attempts to tell a story illuminates the exercise of authority in clinical encounters, and the way in which clinical tasks are embedded in the social process of authoring the accounts of patients’ illnesses.

Introduction

From the time that Hippocrates instructed his students on how to address and query their patients, the art of communicating with patients has been a recurring theme in medical training and practice. Its prominence, waxing and waning in different eras, appears to have declined sharply with the professionalisation of medicine (Jewson 1976; Shorter 1985) and advances in medical technology (Reiser 1978). Currently, there is renewed interest
in clinical communication, marked by proposals for humanistic training of physicians (Baron 1985; Odegaard 1986), textbooks on medical interviewing (Enelow and Swisher 1979; Reiser and Schroder 1980; Billings and Stoeckle 1989), and the introduction of interviewing and interpersonal skills courses in many medical schools and residency programmes (Kahn et al 1979; Engler et al 1981; Lipkin et al 1984).

The hallmark of this recent emphasis, which reflects a view of 'patients-as-persons' ultimately responsible for their own health, is the argument that physicians need to attend to patients' personal concerns, interests, and understandings of their illness experiences. Thus some critics argue that modern medicine, guided primarily by technological imperatives, tends to ignore important therapeutic aspects of the clinical relationship (Balint 1964; Novack 1981), and that the dominant biomedical model obscures and undervalues important emotional, social, and cultural aspects of illness (Engel 1977; Mishler 1981; Novack 1981). Proposed alternative models take these extra-physiological aspects into account (eg, Engel's biopsychosocial model, 1977) and urge physicians to adopt an empathic mode of response and foster a cooperative clinical relationship (American Board of Internal Medicine 1979).

This paper reports a study of how physicians may accomplish these additional tasks. It extends and adds empirical definition to recent programmatic statements on the clinical significance of patients' stories, which suggest that they may reflect patients' understandings of their illnesses (Lipkin et al 1984; Cassell 1985a, 1985b; Brody 1987; Charon 1986, 1989; Kleinman 1988). Furthermore, we draw attention to the essentially social character of stories: they exist within discourses. Focusing on storytelling as a central activity, we undertake a detailed, comparative analysis of the discourses of two clinical encounters: in one, the patient's story occupies the centre of clinical attention; in the other, the patient's story is interrupted.

Sociological interest in patient-physician communication has also increased over the past twenty years, paralleling the renewed attention it is receiving within medical education. Early studies 'coded' discrete statements and compared, for example, the frequencies with which patients and physicians gave or asked for information (Korsch et al 1971), made 'patient-' or 'doctor-centred' statements (Byrne and Long, 1976), used 'technical' or 'non-technical' terms (Waitzkin and Stoeckle 1976), or expressed 'disclosure' or 'advisement' (Stiles et al 1979). A more recent line of research focuses on the structure of the discourse, for example, examining the ways it is organised through question-answer exchanges (Fisher 1984; Fisher and Todd 1983; Frankel 1984; Mishler 1984; Todd 1984; West 1984). Our analysis draws upon and extends the latter studies to describe how particular discourse structures either facilitate or impede the expression of patients' stories. By examining the details of storytelling we reveal aspects of the exercise of authority and its clinical implications.
The structure of clinical discourse

Clinical interviews are structured in ways that limit patients' opportunities to tell the stories of their illnesses. Although patients initiate the encounters and their problems are the central topics, physicians control the process, following a medical agenda to accomplish the primary tasks of diagnosis and treatment. A typical encounter begins with the physician's opening request for the patient's complaint, which is followed by questions that elicit and specify symptoms, and often a physical examination. It concludes with the physician's assessment and treatment plan.

From the physician's perspective, the encounter is essentially a structured interview where she/he asks a sequence of Yes/No or fixed-alternative questions, with patients expected to restrict their answers to only those facts that are 'relevant' to the tasks of diagnosis and treatment planning. This gives the discourse its typical, repetitive three-part structure: physician's first question, patient's response, and physician's next question (Mishler 1984; Fisher 1984; Todd 1984). Most of what physicians say is in the form of questions and almost all questions asked are theirs (West 1984; Todd 1984), largely of the kind that restrict responses, with occasional open-ended questions quickly narrowed by successive, specific ones (Frankel 1984, 1990; Beckman and Frankel 1984).

Patients are attentive to physicians' questions and try to respond appropriately to whatever is asked for, at whatever point, and in whatever form (Frankel 1984; Mishler 1984). However, they often add unasked for information, speak in their own terms or attempt to introduce other topics reflecting their concerns and understandings. Typically, they are interrupted, or their efforts are either disregarded or followed by remedial actions, such as repetitions or reformulations of the original question, which reinstate the physician's agenda (Frankel 1984; Meehan 1981; Mishler 1984; Treichler et al 1984; West 1984).

Mishler (1984) refers to this struggle for control of the discourse as a conflict between the 'voice of medicine,' expressing a technical, biomedical frame of reference, and the 'voice of the lifeworld,' reflecting the patient's personal, 'contextually-grounded experiences of events and problems' (p. 104), expressed in familiar terms. Usually, the voice of medicine dominates the discourse, but the conflict tends to recur throughout the encounter at various levels of intensity.

From their responsiveness to questions, it is evident that patients tend to cooperate with physicians pursuing the medical tasks of diagnosis and treatment. However, recurrent conflict between the respective 'voices' and patients' persistent efforts to go beyond what is asked for suggest that patients have an additional aim that falls outside the boundaries of the typical, narrow medical agenda. This confronts patients with a difficult task, namely to tell their stories of their problems in ways that make sense
to them while cooperating with the physician. The success of this accomplishment may depend on a realignment of the social relationship typically enacted within a clinical encounter, with the physician assuming the role of story recipient and ceding to the patient authority to develop narrative arguments.

Clinical interviews: a comparative analysis

We will compare two clinical encounters, each between a third year primary care male resident in internal medicine and a patient in an outpatient clinic of a large, public teaching hospital. The two patients are typical of the clientele of the clinic, which serves a relatively low income and ethnic minority community: both are middle aged and Black, the man with epilepsy and the woman with diabetes.

The residency programme encourages a form of clinical interviewing marked by empathy, responsiveness, and respect for patients. Residents' encounters with patients are routinely videotaped for training and evaluation. Senior instructors selected two contrasting video-taped interviews for the present study. One, the case of a man with epilepsy, was judged by them to exemplify patient-centred interviewing, corresponding to the goals of the programme, the other, of a woman with diabetes, an encounter where the desired qualities appear to be lacking (Mishler et al 1989). The audio tracks of the tapes were transcribed, using a notation procedure (described in the appendix) that marks many of the features of naturally occurring discourse (Schenkein 1978; Mishler 1984).

Our comparative analysis of these encounters focuses on the patients' stories and the interaction of story telling. We draw upon studies of the structure of everyday narrative (eg, Labov and Waletsky 1967; Labov 1982) and fine-grained analyses of the interactive accomplishment of storytelling in conversation (eg, Jefferson 1978; Jefferson and Lee 1981; Polanyi 1989) in order to highlight the points of similarity and contrast between the two encounters, including the stories themselves and the ways storytelling was either facilitated or hindered in the interaction. Specifically, we will examine differences in interaction with reference to several critical storytelling tasks: negotiating a story topic, setting the scene, and clarifying the action and its results. Subsequently, we explore possible outcomes of these activities in the concluding phase of the encounters. Telling the story, we assume, is not only important to the patient; it is critical to the effectiveness with which physicians can accomplish their clinical tasks. The manner in which storytelling is accomplished may lead to alternative conclusions of the encounter.
Presenting problems: telling illness stories

The two encounters follow nearly identical clinical agendas: determining the present status of the patient’s illness, evaluating changes, and making plans for subsequent management of the illness. For the residents, this entails collecting information on symptoms, compliance with medication regimens, and blood test values – the historically connected clinical facts from which they will make an assessment of the patient’s condition and prescribe appropriate action. For the patients, this entails describing recent significant events of their illness.

Nonetheless, despite this similarity, the opening episodes of the two encounters illustrate contrasting approaches by the residents with consequent differences in patients’ responses and in how these tasks are accomplished. In each case the resident focuses his attention on a significant aspect of the illness and requests an account. For the man with epilepsy, the resident addresses the patient’s report of a seizure he had yesterday, the day before his scheduled appointment. The patient responds with an extended narrative of the seizure episode – a story. In the second case, the resident focuses on how the patient is feeling, given a number of symptoms, but there is no similar narrative; the woman with diabetes presents a fragmented series of symptoms and worries.

Presenting a recent seizure: ‘Well I’m not really worried itz same thing you told me . . .’ (1.1)

This patient’s account of his seizure is a fully realised story, in the formal sense defined by Labov and others (Labov and Waletsky 1967; Labov 1982; Polanyi 1989; Mishler 1986a). He begins with an abstract of its argument: that he is ‘not really worried’ since it is an instance of ‘gettin upset and aggravated,’ a condition that apparently leads to seizures. He then presents a problem, its context, his actions to resolve the problem, and the results of those actions. That is, he introduces the problematic assignment of a challenging brake job by his boss on Tuesday, and orients the resident to the difficulty of working on these brakes, which require that ‘you get right up on the caliper.’ He also highlights the degree of personal challenge by pointing out that he had never repaired ‘brakes on an Audi before.’

Within this developing context, he describes repeatedly interrupted efforts. First, he is hit in the eye by the caliper, suffering a black eye and headache, which required his attention. Second, when he returns to complete the unusually difficult job the next day, he finds that his boss has failed to secure the necessary parts, causing additional delay, which he highlights as personally excessive: ‘It never took me that long before to finish up a brake job.’ With the second interruption, and his turning to
Transcript 1.1

R: Okay so you said you had a "seizure...... yesterday?
{ }

P: Uh u yesterday yesterday about
*...... about eleven o'clock yeah

R: Hmm *.. At work?

P: (h)um hum

R: Okay. uh
{}

P: Well I'm not really worried itz same thing you told me not gettin
ya-know not upset and aggravated and *. I couldn't have-ta uhm...... my
{}

R: hh.hh

boss give me a car Tuesday right? *...... and ...... I workin-on it was an
Audi I never did brakes on an Audi before. ya-know front wheel drive?
{}

R: hh.hh

R: Yeah

P: And * it was a problem. ya-know and I was down all day long * you know
w-- back like this-here. Like the car's on a lift,

R: Yeah

P: But it's two bolts ya-know ya just can't get to-em unless you get right up
on the caliper * and ah twis-- jus can twist a little bit with a
screwdriver. * And I was going like (gangbust) when (it) ya see I got a
black e(h)ye .hhuh

R: (O-)Oh from the "seizure

P: No. From the caliper. One of em fell, to "the eye

R: Oh I see
{}

P: And it hit me there so...... Tuesday night and I had this terrible
headache and all. * So I slept with a ya-know with a ice pack......
over-it all night to keep- tryin to keep it from swelling and all.
*... And then I went back in * yesterday to try to finish it up. It
never took me that long before to finish up a brake job

R: .hh hh.

P: And *...... my boss hadn't got all the parts for it so I start working
on another car-ya-know? * That's when I ended up having the seizure.

R: Okay uhm .hh so: did your boss or someone else see the seizure happen?

work on a second car, he is aggravated and upset to the point of having a
seizure.

The story is a locally occasioned, extended turn at talk in which he
responds to a point raised by a co-participant, and then concludes with a
return of the floor to that co-participant (Jefferson 1978; Polanyi 1989).
Namely, the patient, in telling the story, answers the question and provides
a commentary on the topic raised by the resident. It is not a mere report of the seizure. Typical of stories in conversations and interviews, it involves a complex argument and presentation of self (Labov 1982; Mishler 1986b), both explaining the seizure and presenting himself as a responsible and diligent worker. The story embeds an illness event in the context of his lifeworld, combining personal knowledge, identity claims, and relevant features of the everyday working life in which his illness is experienced and understood. Beyond a description of symptoms, it develops a theme of personal responsibility as the patient portrays himself frustrated in his attempts to meet a challenge at work, explaining the seizure as arising from responsible action within that mundane context.

**Presenting problems of diabetes: ‘I don’t know what’s goin on’ (2.1)**

The second encounter, involving a woman with diabetes, provides a dramatic contrast. This passage follows her opening litany of complaints, which include pain in her mouth, sensitivity to some foods, difficulty swallowing, and the fact that her blood sugar, monitored with a daily ‘finger stick’, is still high. The resident has probed for the specific value she observed, checked her report against his computerised laboratory record, and now focuses their attention on how she has been feeling.

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**Transcript 2.1**

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R: Okay okay .hh uhm aside from this, how have you been feeling. I know the blood sugar’s been up but what=
P: =Terrible=
R: =Yeah
P: Tired all the time. That tired feelin again=
R: =Yeah
P: An-- I-don’t-know. I eat and I’m still sick. so (h)I don’t know
R: Aum .hh with respect to this business up here is that sore if you’re not eating? Or is it only if you take-- It is uh huh=
          {
            }
    P: Yeah there’s pains in it
P: =And it’s- it’s one- one spot right here=
R: =Uh huh
P: It’s real sore=
R: =Uh huh
P: But then there’s like pains in it ya-know how- I don’t know what it is
R: Uh huh okay .hh Fevers or chills?
P: No
R: Okay. ahh have you been sick to your stomach or anything like that? (yeah)
[Sniffle, 9 second pause]
P: [crying] I don’t know what’s goin on
R: ⟨Yeah⟩ *** You feel like you did before that time? (Ya-know yeah)
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Instead of the first patient's coherent seizure story, this patient offers a list of troubling, persistent, recurrent symptoms. She is 'tired all the time' and again, her mouth is 'real sore,' she eats as she's been told, yet she still feels sick every morning. She progressively expands her presentation of problems with details of their daily onset, Judy's [a nurse] advice, her compliance, and its ineffectiveness.

Her account seems fragmentary - a list of disjointed items without the unifying form of a story to connect and account for them. Worried and clearly distressed that she does not know 'what's goin on,' her account nevertheless contains a theme of responsible effort, similar to that of the first patient. Her symptoms inexplicably persist despite her good efforts in compliance with Judy's directions to eat.

**Coordinated activity in telling a story**

Story telling in conversation is an interactional accomplishment, requiring finely coordinated activity by both participants (Jefferson 1978; Polanyi 1989). It requires a modification of the typical pattern of turn taking by
speakers, with one speaker granted the right to an extended turn, accomplished through a complex negotiation (Jefferson 1978). In the case of a clinical encounter, story telling by the patient involves a momentary shift in the social alignment of the interview to a relationship in which the patient assumes authority and the physician becomes the attentive recipient. However, this shift does not interrupt the overall structure of the interview. Story telling begins, develops, and concludes within the structure articulated by physician requests, patient responses, and physician acknowledgements. Hence, the eventual form of a story reflects the interplay of a physician’s agenda in assembling relevant clinical facts and a patient’s efforts to provide a coherent account of his or her experience.

In the following sections, we will examine and compare the two encounters to show how differences in their structures lead, in the first instance, to a well-formed story and, in the second, to an account that lacks this type of coherence and organisation.

Making room for a story: negotiating a topic

The first patient tells the story of his seizure in response to a complex request from the physician, repeated in different ways over several turns (Transcript 1.1). Initially, it is not in the typical form of a question, but is a restatement of what the patient has already reported. The physician stresses the word ‘seizure,’ which marks this topic as significant news: ‘Okay so you said you had a ‘seizure.’ Such topic formulations tend to elicit affirmative replies (Watson and Heritage 1977) and further talk (Garfinkel and Sacks 1970), and function typically as invitations to tell stories (Jefferson 1978).

The resident stops upon citing the news, giving the patient time to respond. After a brief pause, of 0.8 seconds, with no reply, he transforms his statement into a question: ‘yesterday?’ is said with rising intonation. Questions are more direct forms of request than restatements of news, and the resident appears to be asking for more elaboration, but he remains on the topic initiated by the patient. The patient’s response overlaps with and confirms the resident’s temporal reference and adds the time of day and an affirming ‘yeah.’ There is another pause, of 1.2", and the resident asks another specifying question about the setting of the seizure: ‘At work?’ The patient confirms this, but as the resident acknowledges his response, the patient adds that he is not ‘really worried’ about the seizure. He can account for it in terms of the resident’s previous admonishment about getting ‘upset and aggravated.’

This sequence of talk and pauses initiates a negotiation. The resident nominates the seizure as the topic for their ensuing dialogue in casting it as important clinical news, but the patient disclaims worry and apparently rejects the topic. Such a rejection typically calls for a justification (Watson
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Stories typically being with an introductory section that orients the hearer/reader to the scene within which the action of the story will unfold (Labov and Heritage 1977), which is offered with the argument that the seizure is understandable in terms of what both patient and resident already know. The patient pauses (1.1" followed by another of 0.6") on stating his rejection and after the resident's sigh. But instead of speaking at this potential turn transition juncture (see Sacks et al 1974), the resident remains silent, thus offering the patient an opportunity for an extended turn at talk. The patient takes up the opportunity and transforms his prior statement disclaiming worry into the abstract of his story. As the patient begins to expand his statement with details of the problem of working on an Audi, the resident acknowledges the relevance of these facts, thus assuming the role of attentive recipient: ‘(P) ya know front wheel drive? (R) yeah.’

There is no similar negotiated beginning for a story in the encounter involving the woman with diabetes. The resident's open-ended question about how she is feeding (Transcript 2.1) comes immediately after she has reported a list of complaints and troubles. His opening ‘Okay okay .hh uhm aside from this’ appears to dismiss her account of how she is feeling. It also brings an immediate response, summarising what she has already said in one word: ‘terrible.’ The resident quickly acknowledges this: ‘yeah.’

She expands her response, saying she is tired ‘all the time’ and ‘feelin’ tired ‘again,’ which brings a second acknowledging ‘yeah.’ However, when she expands further, complaining that she eats but she’s ‘still sick. so (h) I don’t know,’ the resident shifts focus to her mouth pain, effectively closing the prior opening. Their conversation is close-ordered, with virtually no gaps between turns, and their utterances contain lexical ties (ie, feeling-feelin[g], eat-eating) suggesting close attention. However, the resident displays no attention to her thematic, general concern with how she is feeling, and his series of specific questions cut off rather than invite a story.

Instead, the discourse maintains the typical request-response order of a physician-dominated interview, with the patient remaining an attentive respondent. She provides the information requested and adds expansions that reiterate the gist of her argument. There are pains in her mouth, and she doesn’t know what it is. She experiences no fevers or chills, but she has felt sick to her stomach, which she expresses dramatically, before adding ‘I don’t know what’s goin on.’ Her crying prompts an acknowledgement by the resident of old troubles, and this is followed by an extended elaboration of her daily feelings of sickness. Yet, instead of attending to her distressing and persistent frustration, the resident subsequently focuses on the specific timing of her symptoms. In addition, he transforms her feeling ‘sick’ into the medical term: ‘nausea.’

**Orientation: setting the scene**

Stories typically being with an introductory section that orients the hearer/reader to the scene within which the action of the story will unfold (Labov...
and Waletsky 1967; Labov 1982). This may include time, place, prior events, and actors, as well as evaluative comments highlighting their significance. Understanding the meaning of the story depends on knowledge of the setting, and story tellers must either assume knowledge on the part of the recipient or they must make salient details explicit.

Whether and how the setting is elaborated depends, in part, on the teller's monitoring of the recipient's knowledge and interest in the story's setting. It may also depend on rhetorical decisions the teller makes to express an argument or present the action and the protagonist in a particular light. Hence, orienting and evaluative statements mark what makes the story worth telling; information about the context may be more important than the action itself (Labov 1982). Moreover, the presentation and acknowledgement of orienting information that goes beyond the physician's specific request signals that storytelling is taking place.

Both patients attempt to introduce information that establishes the contexts of their problems. For the man telling a story of his seizure, this includes the personal challenge of working on an Audi's brakes and details of his work setting. This is new information that is not obviously relevant to the report of the seizure as a medical fact, nor is it necessarily familiar to the resident. Thus, as the patient introduces it, he solicits acknowledgements from the resident. The introduction of the work-related problem (i.e., getting a car on Tuesday) is tagged with a request for acknowledgement ('right?'), as is his evaluative comment marking it as a personal challenge ('front wheel drive?'). The resident's responses, acknowledging the relevance of these facts, facilitate the patient's continuing with a description of his actions in this context (Mishler et al 1989).

Whereas a shared orientation to the setting is established in the first encounter, this does not happen in the second. The patient with diabetes appends contextualising information to her responses to questions, but her additions receive little acknowledgement. (See Mishler 1984 for the general absence of physicians' acknowledgements to patients' 'tag' comments.) When they do, she follows with expansions. For example, her tearful reiteration that she does not 'know what's goin on,' prompts the resident to acknowledge a shared history: 'You feel like you did before that time?' She follows with a substantial elaboration of her argument: she is persistently tired in the morning and sick to her stomach despite eating. However, a shared orientation to this history is not maintained, as the resident reframes and pursues a response to his previous question about her sickness/nausea.

Acknowledgments by hearers not only mark a shared orientation to the setting, they also indicate that they are entering into their role as story recipients. In the first case, the resident's acknowledgements and his follow up to his initial question indicate a receptiveness to the story telling itself. After the patient mentions the dramatic development of his black eye, the resident asks whether this was from the seizure. Like his previous request,
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Clarifying the action and its results: story development

The centrepiece of a story is a series of temporally-ordered statements that describe related actions and a resulting change in either the circumstances or the main character, the complicating action in Labov's (1982) model. The first patient, as we have seen, tells of his frustrating work and aggravation that results in a seizure. However, the coherence of his explanation relies on some unstated understandings. Labov (1982) argues that the coherence of a story as a sequence of connected actions is located at an abstract level of underlying propositions, which speakers assume are reciprocally shared with co-conversationalists. For example, the report of
hard work in frustrating circumstances indexes a shared, cultural understand- ing that such a state of affairs typically causes anger. The proposed relationship between this situation and the seizure further indexes background knowledge presumably shared by the patient and physician that emotional upset causes seizures. Thus, one task in telling a story is to present actions and consequences in such a way as to affirm and test unstated relationships. Indeed, the man with epilepsy begins by reminding the resident of their shared understanding of the relationship between emotional upset and seizures: ‘itz same thing you told me not gettin ya-know not upset and aggravated.’ The ensuing story documents this shared understanding.

However, achieving this understanding does not proceed smoothly and without problems. For example, the resident interprets the seizure as the cause of the black eye and is corrected by the patient: the black eye is one of the causes of the seizure. Whereas the resident initially focuses on the seizure as the active cause of subsequent events, the patient presents an alternative chronology and understanding. He highlights his working, not the seizure, as the main action of the story, and emphasising his role as the central character, suggests that the seizure results from his actions, albeit justifiably, given the circumstances.

The woman with diabetes makes similar efforts to clarify the relationship between actions and results. In addition to contextualising her symptoms, she observes that she is eating as she’s been told, yet this does not ‘stop the sickness in the mornin.’ The only result of her eating is a weight gain. However, she faces a complex problem: her expansions beyond requested information receive little acknowledgement. In addition, the link between actions and outcomes remains obscure, and she must not only achieve a shared recognition of them, but clarify their problematic relationship. Repeatedly, she states that her responsible and compliant actions do not lead to expected results. Whereas the first patient implies that his failure to comply with the resident’s recommendation to avoid emotional upset resulted in a seizure, this woman suggests that compliance surprisingly, and distressingly, results in a worsening of her condition. Like her counterpart in the first encounter, she appears to affirm an underlying proposition that compliance ought to lead to relief.

Her efforts to develop a coherent account of her actions and their consequences are repeatedly interrupted by the resident as he pursues the clinical details of her symptoms. Yet she persists, as shown in extracts from their subsequent dialogue. She elaborates that she has changed her actions to be more compliant: she ‘did start eatin’ and she is ‘forcin the food,’ yet she’s ‘still sick on the stomach’ (Transcript 2.2). Somewhat later, going well beyond the resident’s abrupt question about her feet, she makes her problem more explicit by saying that she ‘might feel better’ if she could understand the relationship between what she does and how she feels (Transcript 2.3). This prompts an acknowledging response by the resident,
Transcript 2.2

R: Okay. How long does it take before that feelin of bein sick to your stomach goes away=

{ }
P: = Sometimes it lasts round till round lunch time=
R: = um hum
P: And a- cause I- I- well I told her the truth but I wasn’t .h(h)h in the mornin it wou- ya-know right after I take my insulin I wasn’t eatin. then I start eatin now I wasn’t eatin because I was sick on the stomach. And-ah-- but I did start eatin and it’s still-- ya-know like I say I’m forcin

{ }
R: = yeah

Yeah yeah yeah .hh Do you ever get that feeling any other time of day?
P: = hh. no. Like I said run through-- sometime it runs around till lunchtime=
R: = um hmnm

Transcript 2.3

P: and an-it- it it gets me because I’m not like that you know I- I’m not used to always feelin the best but gees I’m not always tired from doing nothin you know. I just don’t understand it I’m tellin you
R: = hh how are your feet doing these days
P: They’re fine.
R: = (okay)=
P: = Yeah they fine yea:h it’s just been a problems I’m tellin ya=

{ }
R: = Yeah yeah
yeah
{ }
P: And it gets me down I hate to always crack up but-- I jus don’t understand

{ }
R: = Well I--

it. I don’t- if it was somethin I could understand and I don’t know I might feel better but- this here it gets me (and it’s) tirin
R: = hh Well I understand it’s hard again cause it ya-know especially someone who takes care of herself as much as you have and has been doin the right

{ }
P: um-hm:
things you sort of feel like Jesus it’s not fair heh heh .hh
(And also there’s-)
{ }
P: Well no. And then ya know what gets me really is I’m doin ya-know more now than=
but one that minimises the injustice of her condition with a chuckle and misses her point. Like his earlier acknowledgement, this one brings an expansion and correction: it is not simply a problem of unfair outcomes, it is that she is doing better in compliance and feeling worse. This point remains lost.

Both residents hold to a clinical frame of reference that provides for inferences about the meaning of significant facts. The second resident demonstrates this clinical frame in his attention to the woman’s nausea and other symptoms. Similarly, the first resident documents a clinical frame by pursuing the matter of the patient’s seizure in the first place, despite the patient’s denial of its importance. Nevertheless, in assembling the clinically relevant facts, he collaborates (Mishler et al 1989) in the telling of the patient’s story.

Expanding the story

Their collaboration on the seizure story is maintained by the patient and the resident in their subsequent dialogue. After probing for details of yesterday’s seizure and its aftermath, the resident refers to the patient’s chart and asks if it was the first since the patient was hospitalised following a seizure one month earlier. Finally, he asks about the patient’s medication use at the time of the seizure. In sum, the resident pursues a line of questioning that completes the clinical account of the seizure and then locates this symptomatic event within a clinical-historical frame of reference, including prior prescriptions to take necessary medicine. In response, the patient expands and clarifies his story.

Although the patient marks the conclusion of his initial story with a summarising Coda (Labov and Waletzky 1967) (‘that’s when I ended up having the seizure’), the resident asks for more: did his boss or someone else see it happen and did he say what it looked like (Transcript 1.1)? The
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patient quotes the boss’ description (‘he said I was just shakin’) and then tells what he did next. He sent away the ambulance that alarmed coworkers had summoned and called his brother instead. He then went to a neighbourhood clinic, which referred him to the hospital for ‘a shot’. But, told by the hospital staff that little would be done for him at that time (‘they wasn’t going to give me that shot or nuthin’), and since he already had an appointment the following day with his ‘own, regular doctor,’ he resolved to go home and sleep. He felt dizzy, ‘but ya-know wasn’t nothin to worry about.’ The resident utters simple attention markers (eg, uh-hmm) until the patient concludes with his decision to go home and to bed. He then asks how the patient feels today. When the patient reports that he feels fine, except for a pain in his back, which he identifies as an old problem (‘its been messed up before’), the resident turns to the patient’s chart and shifts their attention to the history preceding the seizure.

Hence, the story told when the resident first calls their attention to the seizure is transformed into the first installment of an extended story of an unproblematic (for the patient) seizure. When the resident asks about what it looked like, the patient underscores that it was not as bad as it looked to others. No ambulance was necessary, he knew what to do, and his assessment was confirmed by medical staff that afternoon. In other words, he reiterates that the seizure was not a worrisome event. Reading from the chart, the resident asks if yesterday’s seizure was the first since he ‘got put in the hospital’ and inquires about the shoulder pain the patient had at that time. He then asks how much Dilantin was prescribed at the time of his discharge; the patient reminds him that he had prescribed three pills a day. With this, he asks whether or not the patient had managed to take his pills the days before ‘that’ seizure (Transcript 1.2). The ensuing dialogue becomes an occasion for an elaboration of the story of the seizure as they jointly construct a complex response to this ostensibly simple question.

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Transcript 1.2

R: OK good. hh and during the . . . . . . . ya-know five or so days before you had that seizure had you: managed to take your Dilantin every day?

P: Well I missed two days-ah

R: Which two days do you recall?

P: Ahm I wen- I come to the hospital that Tuesday wasn’t it? I think it’s on Tuesday. I missed that Mond- that Tuesday * . . . . . . and I was going out Tuesday night to ah * . . . . . . . pick up some That’s what I was do I was-

} 

R: Oh you’d run out of pills?

P: Yeah. And I was goin to pick up some

R: Okay
And so I said I'll wait ah... well I got ya-know a couple from my brother because he use em also=

Oh is that right?

Yeah. And I got a couple from him, but it wasn't ya-know enough ya-know for my next day and stuff like that. And I said well... Tuesday when I get off work ya-know I'll go and ah... pick up some ya-know ah I was kind of low on bread so: I said I got some money from my boss and go-an ah pick up some

Okay so: I think you had your seizure Wednesday right? yesterday?

Yeah uh hh.

And you might have missed your pills like on Monday and Tuesday?

Oh no no not this week no

Is that what you were sayin?

"Last" week

That's the last-- last seizure I had-- not this-- not this last seizure I had the seizure before then

You're talking about when you got put in the hospital

hh. um hum

You missed some pills at 'that' time

Yeah

"This" time for this seizure

Ah this time I-- I took em Monday and Tuesday.

Okay?

Yeah=

And ah Wednesday ahhhh... I usually take em when I get to work after I eat

I see

So after I eat ya-know I'll take em with orange juice

Um hum

And I wait about thirty minutes after I eat and then ah... drink my orange juice and take the pills that's the way I usually do it=

Um hum OK On Wednesday did you take your pills?

No I didn't get a chance becau-

You went straight to work

Well, I went ah we start work like what we do is we starts work and then ah we take a break ya-know and eat

I see

And I'll-- ah... we'll we'll eat then ah when I want a-- it only take-ya about five minutes to take the pills so I wait about thirty minutes after I done ate then take the pills so's whiles I's waiting the thirty minutes, I said well ya-know I'll put this other car in here and ya-know-n and be workin-on-it an so I was up on the dash working on it and next thing I was just ahh stretched out ya-know in the car=

Okay
P: So I gets up so then the guy (looked in) and said ah (wait a minute Dave) lay down. He said don't get up and so I said for what? he said just do what I said, lay down

R: (.hh hh. Uh huh)

P: And so I said I'm getting up. So after ah . . . . . . . I started gettin up that's when I realized ya-know what had happened

R: Okay Okay So you'd been working and you'd had your breakfast at work but you hadn't gotten around to takin your pills yet

P: { }

R: { }

P: No I hadn (--)

R: It wasn't quite time to take em

P: No it hadn't been n- long

R: Okay

P: I usually try to wait . . . . . . at least thirty minutes=

R: = Yeah okay And the 'days' before that seizure it sounds like you'd been taking you pills every day=

P: = Uh-hmm=

R: = Right?

P: Um hmm

R: Okay

P: And like I said I got disgusted and all- (frustrated) that Tuesday and (especially) I got a . . . . . caliper hit me in the eye=

R: = Yeah

P: I was really (mad) I didn't wan-- I really didn't want to do the car no

R: Yeah

P: { }

R: Yeah. Okay so you were sick and tired of of the affair. Alright

P: And aggravated

The patient begins by saying that he missed two days. Asked for details, he recalls Monday and Tuesday and then goes on to say that he was going out Tuesday night to 'pick up some.' Whereupon the resident interrupts with a formulation of the unstated problem: 'Oh you'd run out of pills?' The patient confirms this, completes his interrupted utterance by repeating that he was going out 'to pick up some,' and then describes a strategy for coping with this problem that involved his brother and his boss. Hence, they collaborate in telling a story that answers the resident's question. The patient provides descriptions of the action and its social context; the
resident formulates 'missing' details of the problem and the timing of the action. Furthermore, it is a formulation of timing ('And you might have missed your pills like on Monday and Tuesday?') that leads to their noticing and remedying a misunderstanding: the patient has been referring to 'that' seizure which resulted in his being hospitalised a month ago; the resident has been asking about yesterday's seizure.

Once they've focused on the same seizure, the patient describes how he usually manages his medication at work. The resident responds by pressing his now clarified question: 'Oh Wednesday did you take your pills?' The patient answers, 'No,' with a qualification in which he reiterates the workday context presented in the original instalment of this story. His medication routine is carefully articulated with his work schedule, a schedule that was interrupted by the difficult brake job. Moreover, he presents himself as responsible and scrupulously attentive to his medication in this context. In response, the resident proffers a series of formulations of the gist of what the patient is saying, which eventually reflect the patient's apparent motivation. That is, it is not that he 'hadn't gotten around to takin [his] pills yet.' it is that 'it wasn't quite time to take 'em.' With this acknowledgement of his qualified answer, the patient pursues his original point by reiterating, 'And like I said I got disgusted and all- (frustrated) that Tuesday,' 'really (mad),' 'and aggravated.' The resident joins in concluding the story with a final acknowledgement: 'Okay so you were sick and tired of of the affair. Alright.'

Clinical implications of stories

Accomplishing the clinical tasks of diagnosis, treatment, and illness management, which are the primary foci of attention for both patients and physicians in these two encounters, depends on some form of historical reconstruction. In general, the presentation of a patient's condition typically requires assembling relevant data chronologically as an account of an underlying, unfolding process. Diseases are disclosed through such accounts (Riese 1953; Cassell 1985; Charon 1989; Sharf 1990). Like other forms of narrative, these chronicles include a problem – here, manifested by symptoms and physical signs – and action taken to remedy it, which brings the episode to a close. The professional genre, reflected in oral presentations and written case records, stresses 'objective' facts and eschews subject evaluation and personal agency, so apparent in patients' accounts, on the part of the physician (Charon 1989). Although silenced, professional agency remains a prominent but implicit feature of physicians' chronicles of disease and remedial actions (Reiser 1991a, b).

Both patients' narratives follow the clinical form and reflect the biomedical model of disease. The patients actively collaborate in accomplishing the clinical tasks. They begin by reporting symptoms that signify underlying
biochemical imbalances: a seizure for the first patient and nausea, fatigue, and elevated blood sugar levels for the second. Biomedically, these disorders are typically controlled through medication regimens that maintain 'normal' balances. Thus, both discourses focus on the timing, frequency, duration, and severity of symptomatic events. Attention is then directed to whether or not the patient takes medication as required. Once it is established that the patient is complying with prescribed regimens, the issue becomes the physiological uptake of the medication – to be determined by the next step of a blood test. Depending on the test results, medication may be adjusted to resolve the problems.

Thus, the chronicle defines each patient's problem, and, furthermore, it is constructed during the course of the clinical encounter. That is, patient and physician construct a shared historical account of what is the matter with the patient and what they are presently doing to remedy it. They do this within an encounter that is designed to formulate the problem and effect appropriate action, with the emerging narrative reflexively determining what is to be done next to complete the history.

This clinical task is accomplished through the interplay of two voices in the discourse – the voice of medicine and the voice of the lifeworld (Mishler 1984) – which reflect distinct narrative genres. In the first encounter, the narrative incorporates the voice of the lifeworld and reflects a personal narrative style: a genre in which the patient is a protagonist, engaged in responsible, motivated action in complex situations. The illness is part of a personal and interpersonal story. In the second encounter, the narrative reflects the dominance of the voice of medicine and a clinical genre in which the body is the only protagonist: the disease unfolds as a biological mechanism, absent of motivation or feeling, other than symptomatic sensations. Her illness is embodied, but the narrative lacks agency.

These different clinical narratives lead to differences in how the next steps of a blood test and possible adjustment of medication are framed and carried out. For the woman with diabetes, these are technical interventions within a biomedical perspective. In contrast, for the man with epilepsy, the same procedures are interactively framed in a way that acknowledges both the personal struggle depicted in his story and, remarkably, the physician's responsibility.

In the encounter with the man with epilepsy, the resident recommends a blood test by requesting the patient's permission: 'if it's okay with you I would like to have a blood test taken today. Is that all right?' (Transcript 1.3). The second resident bluntly announces that 'we ought to check a sugar in the lab today since you're here' (Transcript 2.4). In addition, while the first resident's request is made with apparent ease, the second resident's announcement comes in the midst of a struggle for the floor: he is twice interrupted and then interrupts the patient, as both speak with increasing haste.
Transcript 1.3

R: I-um-- I wrote you prescriptions for the Dilantin and for the blood pressure pill. Okay? .hh uhm keep takin em in the same way as usual.

P: hmm

(h).hh It it's okay with you I would like to have a blood test taken today. Is that all right? .hh I wanna check and see uhm the level of Dilantin in your blood. The reason is you've been takin it regularly lately and I wanna see if three pills a day is puttin enough drug into your system, okay?

P: uh hum=

R: =because it bothers me a little that you had a seizure yesterday ah even though you're takin your medicine * . . . . . hh uh:mm ** Perhaps I'm not givir ya enough medicine. Okay? And if that's the case why when I get this blood test back I can give you a call and maybe tell ya to start takin four a day. Okay?

P: Okay=

R: =Wait until I get the-- wait until I talk to yah. D-you have a telephone?

P: Yeah

Transcript 2.4

R: .hh Well,^ there are a couple of other things that Doctor Goldman was talking about that I think might be reasonable to try. First of all I think .hh even if *. . . this business is causing your sugar to be up that we still need to get it down lower than it is Okay?

P: uh-hm

R: And that means--

P: I know it's too high.=

R: =Yeah. That's means checking a--

P: I know by my body you know

R: Yeah yeah I understand.=

P: =uh-hmm=

R: =Yeah. ahh I think we ought to check a sugar in the lab today since you're here=

P: =Okay=
R: =and see what's up and I think we're going to have to increase the insulin, okay?

{  

} (Oh God)

P: =Oh God
R: .hh Well' I know that's disappointing to you. i-- That in itself is not-- hh I mean there's a lot worse things than being on a lot of insulin =

P: =Oh I-- I realize that because if you only take five units of

{  

} {  

} 
R: yeah
I-don't-know just so much insulin-- (it upsets me I-don't-know)

The first resident’s request defers to the patient as someone to be consulted in matters requiring his cooperation. The second resident’s announcement effectively bypasses the patient as a responsible party and renders her a subject of clinical imperatives dictated by the resident. Furthermore, the request in the first case is embedded in a complex acknowledgement of reciprocal clinical responsibilities. The resident justifies his request by citing the patient's efforts in taking his medicine 'regularly lately,' as well as his own responsibility regarding medication: 'Perhaps I'm not giving ya enough medicine.'

The second resident, on the other hand, justifies the blood test in terms of clinical expedience. His recommendation, focused on physiology and framed within an assertion of clinical authority, essentially ignores the patient's concerns. Although she asserts that she knows by her body that her sugar is too high, her implicit request for an explanation is deflected. When she reacts in shock to the prospect of more insulin, the resident euphemistically acknowledges her 'disappointment' and trivialises the issue of 'a lot of insulin.' In contrast, the first resident, although similarly concerned with the physiological aspects of epilepsy, frames his request in terms of an acknowledgement of the patient’s story. That is, he acknowledges their reciprocal responsibilities and efforts and locates the blood test within their shared and continuing story of a complex illness, a story that lies at the centre of their collaborative relationship.

Reframing the clinical task

The foregoing comparison reveals significant differences in the ways that essentially similar clinical tasks are accomplished in the two encounters. We have seen the tasks of determining symptoms and medication status in managing chronic illnesses socially accomplished in distinct ways with significantly different outcomes. The realisation of a coherent story is a
prominent part of this accomplishment in the case of the man with epilepsy. Presented primarily in his own terms, and including many details of the everyday context in which his seizure occurred, his account is an extended narrative of the seizure as an episode in his life. His story is the centre of attention and serves as the frame of reference for organising the relevant facts of the seizure and his medication. In contrast, the second patient’s story is not the centre of attention; it is on the margins. The woman with diabetes reports details of her life, expresses misgivings about her condition, and presents a litany of complaints, feelings and observations that document her concerns, but her concerns are treated as digressions from the task of ascertaining her condition. Her story is repeatedly interrupted.

These differences reflect the two residents’ alignments to their patients’ stories. The first resident assumes the receptive stance of attentive listener, repeatedly acknowledging, legitimising, and collaborating in the telling of the story as a presentation of the patient’s condition. In doing so, he grants a measure of authority to the patient. Similar attention and deference is denied the woman with diabetes. The second resident repeatedly asserts his medical authority, maintains his biomedical agenda, and assembles relevant clinical historical facts, while interrupting the patient’s attempts to formulate a coherent story with those selfsame facts.

Qualitatively different ‘conditions’ are constructed within these different clinical relationships: the first locates seizures and epilepsy within the lifeworld of the patient; the second locates diabetes within the woman’s body. These different presentations and relationships set different stages for the residents’ assessments and recommendations in the concluding phases of the encounters. Both encounters unfold around the tasks of constructing a medical problem, taking action, and evaluating its consequences. In the first case, the patient’s illness is much more broadly defined, encompassing the motivated actions of the patient and the social contexts in which he lives with his illness. Consequently, the resident’s response to the patient’s condition entails much more than the technical intervention provided in the second case. Hence, the clinical significance of attending to a patient’s story is that it changes the object of clinical intervention.

Moreover, the micro-alignments of storytelling and the display of recipiency by the resident, entail macro-alignments of reciprocal responsibilities in the patient-physician relationship. Whereas the first resident collaborates with the patient in managing the illness, the second resident eschews a responsibility to help the woman with diabetes make sense of incoherent symptoms suggesting an inexplicably worsening disease. The lack of a coherent story, told with the resident, may be a cause of her distress. In a related analysis, Jefferson and Lee (1981) drew a distinction between a ‘troubles telling’ and a ‘service encounter.’ A service provider in the latter type of situation may carefully avoid acknowledging the personal
elements of a possible troubles telling and the personal reciprocity an acknowledgement would entail in order to prevent a personal relationship from interrupting the efficient delivery of impersonal services in response to a technical problem. Jefferson and Lee emphasise the disruptiveness of troubles telling to a service encounter. The contrast examined here suggests that a service encounter may interrupt a troubles telling. Furthermore, it suggests a more complicated problem, that the patient’s efforts to tell a story may not simply be a troubles telling, but an attempt to make sense of ‘technical’ facts, such as symptoms and compliance with resident’s prescriptions. Whereas part of the patient’s task in consulting a physician may be to get help in making sense of a problematic illness (Kleinman 1988), ‘troubles’ may stem from the frustration of these efforts.

The chronic illnesses presented by these patients highlight this point. Comprehensive assessment and management of diabetes and epilepsy entails integrating biochemical processes and pharmacological interventions with a host of psychological and social aspects of patients’ lives (Fisher et al 1982; Hauser and Pollets 1979; Jacobson and Hauser 1983; Schneider and Conrad 1983). The pathology of these diseases is complicated and physicians face ongoing uncertainty. Patients, for their part, face recurrent problems of living with a chronic illness: minimising the disruptive effects on their lives of the illness and of complicated and demanding medical regimens, and attempting to maintain personal self-control while facing uncertainty about their prognoses.

Yet, clinical attention is often narrowly focused on biochemistry and pharmacology, with the level of medication required to effect ‘control’ representing the status of the disease, to the exclusion of all else (Posner 1977; Schneider and Conrad 1983). Nonetheless, such control requires that patients act responsibly beyond the boundaries of the clinical encounter. Our analysis suggests that issues of responsibility are expressed in patients’ stories. Hence, expanding the frame of reference and taking more of the patient’s experience into account, in addition to improving patient satisfaction (Schneider and Conrad 1983), may actually improve physiological control of these diseases (Jacobson and Hauser 1983; Laron et al 1979; Kaplan et al 1989). Indeed, our analysis suggests that the resident’s alignment to the patient’s story in the first encounter enabled them to recognise and remedy an error regarding the patient’s medication at the time of the recent seizure, an error with both clinical significance and implications for their reciprocal responsibilities in the management of the illness.

Finally, by providing some clarification of how ‘the patient’s story’ is produced, our analysis has implications for sociological theory and research on clinical practice, particularly for studies of patient-physician interaction. Programmatic statements tend to construe the story as something that a patient brings to the clinical encounter, as expressing the patient’s perspective, cultural background, biography or an enduring
feature of personality (see, for example, Brody 1987; Kleinman 1988). Based on our analysis, we would caution against the risks of reifying ‘patients’ stories.’ A patient’s story is a specific narrative reconstruction of illness constituted within a specific social interaction at a particular time and place. What is included in the story and the way in which it is expressed results from contingencies of that interaction and, in turn, shapes that interaction. More precisely, the story is an integral component of the interaction that both reflects and reflexively informs and guides that interaction. Actually, to speak of the realised narrative as the patient’s story is something of a misnomer, since it emerges in the context of requests, acknowledgements, expansions, and elaborations. It represents the joint effort of the patient and physician to make coherent sense of a problem within a jointly constructed context of actions and results.

To show how this happens, we have reframed the clinical task as a social accomplishment realised in discourse. Furthermore, we focused our analysis on the patient’s efforts to tell a story within the context of clinical discourse. Studies of clinical communication (with a few exceptions, eg, Mishler 1984) tend to assume the dominance of physicians and the biomedical model, and their analyses and interpretations rely, unreflectively, on that assumption. By shifting the focus to the patient’s active role in the discourse, we have made this assumption problematic. Attending to the patient’s authorship of her/his story highlights the vicissitudes of authority in clinical encounters and the social transformation of illness in clinical relationships. The patient’s experience is either recognised or reduced as social alignments are enacted. Attending to the patient’s story clarifies how the ‘technological task’ of medicine is irremediably framed within social relations. The clinical fact of the patient’s medical condition reflects the exercise of authority – that is, authorship – in the encounter.

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Appendix

Transcript notation

?. Punctuation marks indicate intonation. A period marks sharply falling intonation; a question mark indicates rising intonation.

* Carats indicate marked emphasis.

{ } Enclosed words spoken softly.

: Colons indicate elongated vowel sounds.

- Hyphens indicate abruptly truncated portions of utterances.

= Equal signs indicate latching of successive utterances with no discernible gap.

.hh hh An ‘.hh’ indicates an audible inhalation; ‘hh’ indicates an audible exhalation.

...* Series of periods indicate pauses, with each period a tenth of a second. Pauses of one second are marked with an asterisk.

{ } Braces mark the location of simultaneous speech.

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