SEEKING INFORMATION IN A MEDICAL SETTING: VIETNAMESE DOCTOR-PATIENT INTERACTION

A Thesis submitted by

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Abstract

Eliciting information about a patient's health concerns is a fundamental task that all doctors engage in. It enables the doctor to gather relevant information about the patient's pathological status, which is then used to inform their diagnosis, propose a treatment plan, and/or recommend appropriate interventions. At the same time, the patient's provision of information is also partly shaped by the doctor, whose deployment and use of elicitation strategies can play a role in the quality and quantity of the information the patient discloses. This study examined how doctors elicited and sought information from their patients, how patients disclosed information to their doctors, what information doctors elicited and sought, and what information patients disclosed, during medical consultations at two public hospitals in Vietnam. The data were gathered from audio-recordings of 66 primary care visits involving 15 doctors and 66 adult patients. Demographic data were collected using standard questionnaires. The data were analysed using conversation analysis methods.

The findings showed that information exchanges between doctors and patients were dispersed throughout the consultation, from the very beginning until after its termination. In the initial stages of the visit, patients talked about their major concerns. This information established the main reason for the visit, and often influenced the trajectory of the interaction that followed. Once the patient's chief concerns became known, the doctor explored these in detail by eliciting information relating to the presenting problem or to the patient's medical history. In the former case, the doctor updated the patient's condition, noted their symptoms, and/or established the causes and duration of the problem. In the latter, the doctor focused on past diagnoses and treatments, lifestyle issues, and past individual medical problems. These two types of information played a key role in shaping the treatment, in which the doctor offered multiple treatment options and/or sought the patient's agreement with the recommended treatment plan. In recommending this plan, the doctor also collected some information about the patient's life-world (e.g., difficulties with day-to-day living).

The findings also revealed that doctors used questions as their main type of information elicitor. They also used partial and/or full repeats of patients' responses, fishing devices or examples of patients' conditions, and/or assessments of patients'

information. Patients employed five different strategies to disclose information to doctors: using examples, producing a narrative, invoking the opinion of a third party, elaborating on their responses, and making a list. These strategies enabled patients not only to provide the information being elicited by doctors but also to demonstrate their knowledge of the main problem, disclose minor problems, establish the reasons for the visit, increase the perceived severity of the problem, and make an assessment of the problem. Such information was volunteered without being elicited in several cases.

The findings of this study can be used as a resource for the training of medical students on how to interact with patients. Hence, this study contributes to enhancing the quality of medical care, especially in the cultural context of Vietnam.

Certification of thesis

This Thesis is entirely the work of Hương Thị Linh Nguyễn except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

Principal Supervisor: Professor Shirley O'Neill

Associate Supervisor: Dr Gavin Austin

Associate Supervisor: Associate Professor Andrea Lamont-Mills

Student and supervisors signatures of endorsement are held at the University.

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List of abbreviations

CA	conversation analysis
CLA	classifier
COP	copula
D	doctor
DDF	different doctor follow-up visit
GP	general practitioner
HON	honorific
INTJ	interjection
INT	interrogative
P	patient
PERF	perfect aspect
PL	plural
PROG	progressive aspect
PRT	particle
PST	past tense
QIS	question in search of information
SDF	same doctor follow-up visit
TCU	turn-constructional unit
TRP	transition relevance place
USA	the United States of America

Transcription notation

The transcription notation used in this study is Jeffersonian (2004b), and is compiled from Gardner (2001) and Sidnell (2010). Adaptations have been made to accommodate certain features of the Vietnamese data (see Section 4.7).

1. Utterances

.	A stopping fall in intonation, but not necessarily the end of a sentence.
,	A slightly rising, continuing intonation, but not necessarily between clauses or sentences.
?	A strongly rising intonation, but not necessarily a question.
¿	A rise stronger than a comma, but weaker than a question mark.
*	Creaky voice.
↑	A shift into especially high pitch in the talk immediately following the arrow.
↓	A shift into especially low pitch in the talk immediately following the arrow.
.hhh	Audible inhalation.
hhh	An outbreath.
$	Audible smiling while talking.
w(h)ord	A plosive sound associated with laughter, crying, breathlessness, etc.
wor-	Cut off or self-interrupted talk.
< word >	The bracketed talk is markedly slowed or drawn out compared to the surrounding talk.
> word <	The bracketed talk is speeded up compared to the surrounding talk.
WORD	An especially loud sound.
#word#	Clipped talk.
^{o}word^{o}	The sound is quieter than the surrounding talk.
wo:rd	The prolongation or stretching of the sound; the more colons, the longer the stretching.
<u>w</u>ord	Some form of stress.
w-w-word	Stuttering talk.
word+word	Joining together two or more words in the Vietnamese transcription or

the interlinear morpheme gloss

2. Sequential relationships

[The point of overlap onset.

]   The termination of an overlapping utterance.

=   Contiguous talk with no gaps and no overlaps.

3. Intervals within and between turns

(.)   A very short pause of less than 0.2 seconds.

(0.0)   Elapsed time in tenths of a second. For instance, (0.4) is a pause of four

             tenths of a second.

4. Other markings

(word)   Uncertainty on the transcriber's part, but representing the most likely

             possibility.

(   )   Something that the transcriber did not hear.

((word))   The transcriber's description of events.

Chapter 1

Introduction

1.0 Introduction

We are all potential medical patients for, at some time or another, we will have to visit a doctor for medical advice. This meeting between a patient and a doctor is termed a medical consultation, in which the patient is a health seeker and the doctor is a health provider (Lichstein, 1990). In that meeting, verbal communication is central to clinical practice, and is the key to a successful medical consultation (Brédart, Bouleuc, & Dolbeault, 2005; Ley, 1988; Swartz, 2014; Talen, Muller-Held, Eshleman, & Stephens, 2011). It is the main device used by patients to convey their health concerns, and for doctors to gain insight into these concerns. As Ong, Haes, Hoos, and Lammes (1995) posit through their review of medical-sociological studies, doctor-patient communication has three primary aims: (i) to create a good interpersonal relationship; (ii) to exchange information; and (iii) to enable treatment-related decisions to be made. These aims are interrelated and intertwined, and play a key role to treatment outcomes.

Given that the ultimate goal of a medical visit is to address patient concerns and improve their health, eliciting information about patient health concerns is a fundamental task during medical consultations (J. Silverman, Kurtz, & Draper, 2013). This thesis, therefore, examines these information-seeking activities during medical consultations at two public hospitals in Vietnam. In the present chapter, I lay the foundation for this study by highlighting the importance of pursuing the specific topic of the thesis. The chapter begins by delineating the problem that this study seeks to address, and states the aims and research questions relating to the study. It then presents the analytical framework adopted herein and defines the key terms. The chapter concludes by providing an outline of the remaining chapters.

1.1 Problem statement and aims of the study

When attending a medical consultation, a patient expects to receive effective treatment for a health problem so that they can return to functioning normally or as close to normal as possible depending on the problem. Returning the patient to this state is one of five professional roles of the doctor (Parsons, 1951). In order to do

this, the doctor needs to obtain enough information from the patient to be able to form a comprehensive understanding of their primary concern or concerns. This elicitation practice is done primarily through interacting with the patient. Elicitation practice refers to the techniques that the doctor uses in order to gather information of patient problem (J. Silverman et al., 2013). It enables the doctor to obtain relevant information about a patient's pathological status which is then used to inform their diagnosis and propose a treatment plan (Bickley & Szilagyi, 2013).

Just as the doctor is an expert in making a diagnosis and recommending and providing treatment, the patient also has expertise regarding their medical history, values, intuitions, and experience (Roter & Hall, 2006). Internet access as well as the information disseminated by other medical experts means that nowadays some patients may be better informed than their doctors (Hall & Roter, 2006). Labelled as 'lay doctors' or 'expert patients', patients come to the medical visit to seek a second expert opinion, that is, the doctor's opinion (Sarangi, 2001). However, what patients bring to the meeting is unknown to doctors unless patients reveal it. Thus, identifying the patient concern is a must for doctors, as it provides up to 60-80% of the information that doctors need in order to make an accurate diagnosis (J. Silverman et al., 2013; Takemura, Atsumi, & Tsuda, 2007) and to fulfil their role of restoring patients to a non-pathological state.

At the same time, the patient's provision of information is somewhat influenced by doctors, whose deployment and use of elicitation strategies can play an influential role in the nature, breadth, and depth of the information patients disclose (Claramita, 2012; Jenkins et al., 2015; Robinson & Heritage, 2006). The doctor's role comes to the forefront at the outset of the consultation through their elicitation of the patient's chief complaint or presenting problem (Robinson, 2006). This situation continues in the history-taking phase of the consultation, where the patient's responses are often shaped by the design of the doctor's elicitation (Stivers & Heritage, 2001). Similar shaping continues to operate as the consultation moves towards diagnosis (Peräkylä, 2006b) and treatment (Roberts, 1999), since these two stages feature the doctor's delivery of diagnosis and treatment recommendation with little patient information disclosure. Overall, doctors seem to be an information gatekeeper across different stages of the consultation. They shape the trajectory of the consultation and influence the patient's participation in the consultation.

In light of the importance of medical communication, plus the perceived poor communication skills of some medical staff, which can reflect negatively upon the medical system (Ministry of Health [MOH], 2015), special attention has been paid to doctor-patient communication in Vietnam. This has been done through government directives or circulars, as well as specific communication training of medical students at universities (MOH, 2014, 2015). Culturally in Vietnam, the precept 'the doctor is regarded as the patient's 'mother'' has become a guideline for medical staff, who are expected to devote their lives to medicine, and make patients their absolute priority (Q. Nguyễn, 2015). This is reflected in the doctor's interpersonal practices (e.g., care and friendliness), which are expressed, at least in part, via verbal communication. Notwithstanding these, each doctor also has their own communication strategies that they use when seeking information from patients, which may be more or less impacted by various factors. For instance, doctors at public hospitals often have heavy workloads (Beran et al., 2009; Đặng, 2014; H. Q. Nguyễn, 2014), so they may have to decrease the amount of time they allocate to each consultation. Accordingly, they may be unable to collect all information needed for diagnosis and treatment.

Given the important role of information-seeking activities[1] in medical visits, some attempts in the literature have been made to gain insight into how this unfolds in the Vietnamese and non-Vietnamese medical contexts (e.g., Beckman & Frankel, 1984; N. T. H. Phạm, 2014). However, as will be outlined in Chapter 3, most of these studies have shortcomings. Thus, the present study aims to address these general shortcomings. Moreover, it does so within the Vietnamese medical context, as research on doctor-patient interaction to date has tended to focus largely on Western rather than Southeast Asian medical settings or countries such as Vietnam (Claramita, 2012; Claramita & Susilo, 2014; H. T. L. Nguyễn & Austin, 2018a; H. T. L. Nguyễn & Austin, 2018b; H. T. L. Nguyễn, Austin, & Châu, 2018; H. T. L. Nguyễn et al., 2018; N. T. H. Phạm, 2014). As cultural norms may influence medical communication practices and strategies, the paradigms of doctor-patient communication in Western cultures may not be generalisable to this context. Thus, the findings of this study have the capacity to provide empirical data on the elicitation practices of Vietnamese doctors and information disclosure practices of

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[1] See Section 1.3 for a precise definition of this type of activity.

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Vietnamese patients, thereby explicating the patterns of interaction between these doctors and patients during medical consultations.

With this, this study seeks to answer the following research questions:

- How doctors elicit and seek information from their patients in medical consultations.

- How patients disclose information to their doctors in medical consultations.

- What information doctors elicit and seek, and what information patients disclose, in medical consultations.

1.2 Analytical framework

Given its aim of analysing talk-in-interaction in an institutional setting, this study employs Conversation analysis (henceforth, 'CA') as its central research method to explore how doctors elicit and seek information and how patients disclose this requested information (see Chapter 4 for further details). Conversation analysis is "an approach within the social sciences that aims to describe, analyse and understand talk as a basic and constitutive feature of human social life" (Sidnell, 2010, p. 1). In other words, it studies talk-in-interaction by describing the intertwined construction of practices, actions, activities, as well as the overall structure of the talk (Stivers & Sidnell, 2012). Conversation analysis offers an analytical method to identify underlying rules orienting the interaction (Edwards, 1995), hence highlighting how interactants jointly construct their own reality through discursive strategies.

Conversation analysis has long been established as a research approach well suited for the analysis of institutional talk generally, and the medical discourse specifically (Chatwin, 2004; Drew, Chatwin, & Collins, 2006; Gill & Roberts, 2012; Heritage & Maynard, 2006a, 2006b; Maynard & Heritage, 2005). This approach is appropriate for the analysis of medical discourse on the grounds that features of everyday conversation (e.g., turn-taking, informing, describing, complaining, giving advice, or requesting), which are the focus of CA, can also occur in medical consultations (Goodwin & Heritage, 1990; Heritage & Maynard, 2006a, 2006b). In the current study, CA is used to examine the structures and actions of actual medical consultations with a view to unpacking the sequential orderliness of doctor-patient interaction as an active social phenomenon (Adolphs, Brown, Carter, Crawford, & Sahota, 2004). In so doing, the patterns of talk between doctors and patients during information-seeking activities in this study will be made explicit, which in turn will

yield a more nuanced understanding of Vietnamese doctor-patient interactions that may not be possible with other research approaches. The more detailed the analysis of doctor-patient interaction is, the deeper the insight it can offer for the improvement of healthcare. Last but not least, the application of CA to Vietnamese medical discourse contributes to the growing body of CA research that focuses on developing nations and non-English speaking contexts (Gill & Roberts, 2012).

1.3 Definitions of key terms

For the purpose of the present study, the following key terms are defined.

A '(medical) consultation' is a meeting between a doctor and a patient in which the former is a specialist with expertise in a particular field of medicine, and the latter seeks expert advice or counselling for their health concern (Agius, 2014). In this study, the term '(medical) visit' or '(medical) interview' is used interchangeably with 'consultation'.

A 'doctor' in this study is a medical doctor whose practice is not oriented to a particular area of medicine. They provide primary and continuing medical care relating to all acute and chronic illnesses, regardless of the age or gender of the patient.

'Information-seeking' activity in this study covers not only the *gathering* of information by doctors but also the *provision* of information by patients, except where indicated.

1.4 Thesis outline

The remainder of this thesis is structured into seven chapters. Chapters 2 to 4 present the theoretical and methodological background for the research. In particular, Chapter 2 discusses the conceptual framework on which this study is based. It then touches upon the issues of Vietnamese language and culture in relation to doctor-patient interaction. The basic assumptions of CA are also addressed here. Chapter 3 reviews the literature relevant to the study in order to establish a theoretical background for the research and identify the gaps in literature. From the literature review flow the three research questions that this study aims to address. Chapter 4 describes the research methodology used to conduct the study. In particular, it justifies the use of CA as an approach to explicate the information-seeking activities in Vietnamese medical consultations.

The analytical chapters 5 to 7 report and also discuss the findings of the study. They are presented in accordance with the normative structure of a medical consultation identified by Byrne and Long (1976). Chapter 5 is concerned with information-seeking activities which occur during the problem presentation phase. It analyses the doctor elicitation of the patient's problem presentation, and the patient strategies in disclosing their problems. Chapter 6 looks at the doctor elicitation and the patient disclosure of information during the history-taking and physical examination stages. Various kinds of information are elicited and disclosed during these stages: recovery assessment, symptoms, causes, duration, past diagnoses and treatments, lifestyle issues, and past problems. Chapter 7 deals with treatment recommendation and the information that is elicited during the prolongation of the consultation.

Chapter 8 concludes the thesis. It returns to the three research questions posed in Chapter 3 and demonstrates how these questions have been answered in the present study. This chapter goes on to indicate the contributions of the thesis, acknowledge its limitations, and suggest directions for future research.

Chapter 2

Theoretical and methodological background

2.0 Introduction

Chapter 2 sets the theoretical and methodological background to researching Vietnamese doctor-patient interaction. Section 2.1 sketches out the conceptual framework on which the present study is based, and grounds the research design. Sections 2.2 and 2.3 touch upon the doctor-patient relationship in its cultural context, and provide background information about the language used in this situation, respectively. In Section 2.4, I give a brief account of the CA paradigm. A more detailed description of the workings of CA is provided in Section 4.8.1.

2.1 Conceptual framework

Given that features of everyday conversation can also occur in institutional talk (Goodwin & Heritage, 1990; Heritage & Maynard, 2006a, 2006b), it is important to differentiate between everyday talk and institutional talk. Everyday talk refers to the form of casual, social interaction that recurs constantly between relatives, acquaintances, or friends (Markee, 2000). Levinson (1983) defines it as the kind of talk in which two or more interlocutors freely take turns in speaking, and it generally takes place outside particular institutional settings. However, according to Heritage (2005), everyday talk is neither restricted to a specific context nor executes a particular task. This means that it can occur in institutional contexts as well and does not pursue a specific aim. For instance, a person is typically involved in numerous everyday conversations during the course of a normal day with colleagues, family members, friends, or clients, in the form of social chit-chat. These conversations can transpire through different media or channels of communication such as face-to-face, telephone, or internet (Drew & Heritage, 1992; Fisher & Todd, 1986; Heritage, 2005). As a form of social chit-chat, everyday talk does not often contain specialised language. In addition, all interlocutors often contribute to the conversation (such as by taking turns or interrupting) in an equal manner with no one dominating it, respond in a prompt manner, and locally manage the course of their interaction without pre-determining the turn size, order, or content (Fisher & Todd, 1986;

Franke, 2011; Nofsinger, 1990; Sacks, Schegloff, & Jefferson, 1974).

Unlike everyday talk, institutional talk is often informed by the asymmetrical relationship between interlocutors and aims at accomplishing a particular task. As an exchange of talk in which at least one interlocutor "represents a formal organisation of some kind" (Drew & Heritage, 1992, p. 3), institutional talk often involves one or more experts having expertise in a specialised field, and a layperson with little knowledge of the field. The direction of the interaction often lies in the hands of the expert group rather than the layperson (Fisher & Todd, 1986), which results in interactional asymmetry. This kind of asymmetry is organised and institutionalised (Van Dijk, 2002) due to the predominantly question-answer pattern of interaction (i.e., there is little opportunity for the layperson to take the initiative), the inequality in the epistemics of both interlocutors, and the differential positions of both interlocutors regarding their expert and lay statuses (Drew & Heritage, 1992; West, 1984a). This asymmetry is reflected in the unequal contribution of interlocutors to the interaction. Additionally, Drew and Heritage (1992) argue that institutional talk is goal-oriented, that is, it tends to be restricted regarding the verbal activities to be performed, and how interlocutors 'package' them in the talk (Drew, 1991).

Another aspect of institutional talk is that it can take place in both formal and non-formal settings (Heritage & Greatbatch, 1989). Conversation analysis considers institutions to be constructed through interaction, that is, the physical environment (e.g., a family dinner vs. a doctor's office) does not determine the nature of interaction that takes place within in (Drew & Heritage, 1992). The difference between these types of setting lies in the presence of an audience (in the former setting) that may affect the turn-taking procedures. The former setting includes interactions in courtrooms, classrooms, or news interviews. The latter includes medical, social service, or business environments, and mostly occurs in private (e.g., a room) rather than public contexts. Informal institutional talk also exhibits considerably less uniformity than the formal variety (Heritage & Greatbatch, 1989). However, interlocutors in both types of setting still orient to relevant institutional rules. This is displayed in linguistic features, interaction organisation, social epistemology, and social relations (Drew & Heritage, 1992; Heritage, 1997) which govern the production and management of their tasks or activities. Moreover, it is through interaction in these settings that interlocutors' institutional identities are oriented and accomplished (Rutkowski, 2013; Yang, 2009). In other words, this form

of talk underscores the interlocutors' orientations to their respective identities, and to the roles and activities pertaining to those identities (Drew & Heritage, 2006a).

As a main feature of institutional talk between an expert and a layperson, asymmetry is present because of the institutional context, and is significantly increased or decreased by cultural factors (Schegloff, 2005; Tse, Tang, & Kan, 2015). From a CA perspective, institutional asymmetries (or cultural factors) are enacted, managed, constructed, and negotiated through talk. They are not some forces that exist outside of the interaction, but are brought to life in interaction. Language, culture, and interaction are inextricably intertwined and interrelated. Through communication, culture characterises the common-sense knowledge about interlocutors and the inventories of their possible actions (Gudykunst & Matsumoto, 1996). In other words, interlocutor's characteristics and behaviours are often revealed through their interaction. Hence, failure to explore the interconnectedness of language and culture may result in a misunderstanding and misinterpretation of the discourse. That is, interlocutors are likely to use their own cultural values and concepts in the course of interpreting another's communication.

This thesis is concerned with one variety of institutional talk (i.e., medical discourse) which occurs in the non-formal setting. It is called the non-formal setting as the medical consultations in this study occurred in either a consulting room or a ward without the participation of the third party (e.g., the patient's family member). Medical talk can be the exchange of clinical ideas between two health experts, or a medical consultation between a healthcare provider and a patient (i.e., a layperson seeking advice/counsel regarding their health concerns). The latter case, which is the focus of this study, requires the interlocutors to orient to, and enact, their specialised tasks in accordance with their understanding of institutional norms (Drew & Heritage, 2006a; N. T. H. Phạm, 2014). The talk often revolves around the patient's bio-medical condition and other topics such as their social life or daily routine, with the objective of gaining information about patient health issues.

As a form of institutional talk, medical discourse is, therefore, also institutionally bound, and this type of discourse is necessarily embedded within a particular cultural context. It is normally grounded in institutional settings in the form of consultations rather than daily conversation. Medical consultations are characterised by an asymmetry between a health professional and a patient, in which the former often takes the lead. Such asymmetry reflects: (i) the patient's dependency

on doctors for healthcare, (ii) the doctor's authority based on their specialised knowledge, and (iii) the doctor's professional prestige (West, 1984a). In addition, there are also cultural factors that increase or decrease such asymmetry. For instance, doctors from cultures of high power distance, collectivism, and masculinity like Vietnam (Hofstede, 2001; V. Q. Trần, Tô, Nguyễn, Lâm, & Trần, 1998), tend to create great power asymmetry in medical interactions compared to those from cultures of low power distance, individualist, and less masculinity.

To recap, institutional talk differs from everyday talk in terms of linguistic features, specific aims, and interactional organisation (Drew & Heritage, 1992; Yang, 2009). In addition, institutional talk is constrained by the specific institutional context where the interaction takes place, and, more broadly, by the culture which interlocutors come from (Aarons, 2005; Fisher & Groce, 1990; Fisher & Todd, 1986; Schouten & Meeuwesen, 2006; Street, 2003; Wodak, 2002). The current study focuses specifically on talk in the *institutional* context of the Vietnamese public hospital system, which in turn is embedded in the broader *cultural* context of Vietnam. For the sake of simplicity and consistency, in attempting to account for my findings later on, I will focus more often on the institutional than the cultural context for the present study, as the former type of context implies the latter. This framework is depicted in Figure 2.1.
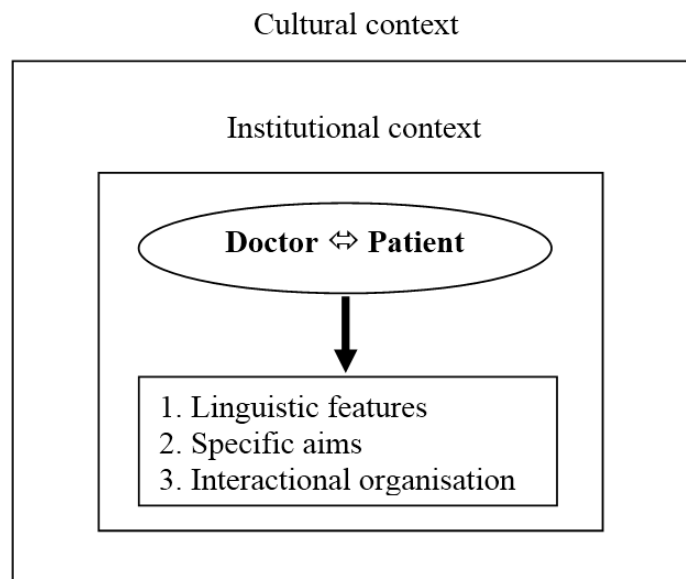
Cultural context

Figure 2.1. Conceptual framework for the study of doctor-patient interaction

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Given this contextual embedding, it is useful at this juncture to elaborate on the Vietnamese cultural context as necessary background for the Vietnamese doctor-patient relationship itself.

2.2 Vietnamese doctor-patient relationship in its cultural context

Vietnamese culture is characterised as collectivism (Bảo Đạt[2], 2001; Hofstede, 2001; V. Q. Trần et al., 1998), deriving from an agrarian lifestyle which emphasises the role of community and interdependence among people for cultivation (T. N. Trần, 1999). This community-oriented lifestyle has, to some extent, become ingrained in people's thoughts and behaviour, and affected their communication (Centres for Disease Control & Prevention, 2008). The influence of collectivism on communication is summarised in six features by T. N. Trần (2006). First, Vietnamese love communication on the one hand but are very timid on the other. They tend to communicate actively and enthusiastically with members within familiar circles in their community, but become reticent and less assertive in interactions with strangers. Second, relationship is taken as a rule of conduct in communication. In other words, emotion is often more important than rationality. Third, Vietnamese have a habit of learning about interlocutor demographics (i.e., age, occupation, education, or marital status) as a means of showing their concern for them. Fourth, living in a group-oriented community, Vietnamese people value their own honour. This is manifest in the concept of face-saving in communication. Fifth, such a communication style is also buttressed by the doctrine of Confucianism, with an emphasis upon harmony and appropriateness (Appel, 2013; Duiker, 1983; Marr, 1981; McLeod & Nguyễn, 2001; L. D. Nguyễn, 1994; N. T. H. Phạm, 2011). Harmony is realised through an indirect speaking-style, non-assertiveness, and conflict avoidance (DeBonis, 1995; LaBorde, 1996; T. P. Lê, 2011; C. Nguyễn, 1994). Appropriateness means showing respectful attitudes towards others, particularly to people senior in age, in authoritative positions, or in high social standing (Appel, 2013; T. Đ. Huỳnh, 1989; T. P. Lê, 2011; T. Q. N. Trần, 2013), through demeanour and differentiated speech in conversation with different people in specific contexts (McLeod & Nguyễn, 2001). In essence, underlying Confucian

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[2] Vietnamese authors without a surname are cited in full.

principles stress harmony and respect in communication as a means to sustain the social hierarchy. Sixth, Vietnamese have a rich system of terms of address and reference as a reflection of social hierarchy and power distance.

Moreover, collectivism and Confucian values have shaped not only daily interactions but also institutional talk (T. C. Nguyễn, Nguyễn, Nguyễn, & Trần, 2015). Srichampa's (2003) study on politeness strategies in Hanoi Vietnamese speech found that, in everyday conversation, people address those senior in age or status in a respectful manner by prefacing their utterance with honorifics *dạ* or *thưa*. In educational contexts, studies by H. T. Nguyễn (2002) and T. C. Nguyễn et al. (2015) showed that, during lessons, students tend to remain silent and reticent as an indication of respect until they are invited to answer questions by teachers. In addition, students rarely question, challenge, or interrupt teachers, enacting the rule of appropriateness and harmony. Therefore, the teaching style in Vietnam is deemed teacher-centred, with mostly one-way communication. Though student-centeredness has long been argued for in education, this approach has not been fully adopted in Vietnam (T. C. Nguyễn et al., 2015). In the business context, T. Q. N. Trần's (2013) study on Vietnamese refusal strategies in intercultural interaction also found that people's choices of these strategies are constrained by the social status of their interlocutors. Specifically, when refusing to act on a request from a superior colleague, people tend to employ more face-saving strategies than they do with a subordinate, out of respect for their superior.

The above findings imply that in institutional interactions in Vietnam, people often show respect to their providers (e.g., teachers or bosses) by avoiding assertiveness, conflict, challenge, or disagreement in communication. However, this may not be the case for all seeker-provider relationships as this will also be contingent upon their age, education, and social status.

As a form of institutional talk, Vietnamese healthcare communication is, by implication, influenced by Vietnamese cultural factors. Several research studies on Vietnamese migrants in The United States of America (USA) revealed that Vietnamese patients typically acquiesced to the doctor's prescribed treatment regimen, whether they agreed with it or not, and rarely raised questions or voiced disagreement with their doctors (e.g., Fancher, Tôn, Meyer, Hồ, & Paterniti, 2010; G. T. Nguyễn, Barg, Armstrong, Holmes, & Hornik, 2007; K. Trần, 2009). H. Hoàng's (2008) study on Asian migrants in Australia found that Vietnamese patients

tended to endure pain in silence without complaining or questioning. N. T. H. Phạm's (2014) finding in the Vietnamese context also concurred with the above conclusions by showing that Vietnamese patients were conditioned to passively listen rather than query or criticise.

To conclude, Vietnamese institutional talk in general is bound by cultural features, and doctor-patient communication is no exception. The institutional context of doctor-patient communication in a hospital informs the language that is used by both interlocutors. This language is the topic of the following section.

2.3 Language used in Vietnamese doctor-patient interaction

This section describes some basic characteristics of Vietnamese language for a better understanding of Vietnamese doctor-patient interactions in the present study. First of all, an understanding of the system of terms of address and reference used in Vietnamese is a sine qua non in analysing doctor-patient discourse, as naming practices can reveal the nature of a participant's status relationship and the overall degree of intimacy between these participants. This element of Vietnamese language is complicated, with its own rules and cultural norms (Farris, 2012; H. V. Lương, 1990). In addressing and referring[3], Vietnamese consider not only gender and number of referents, but also contexts or speech situation, and outside factors such as the participant's attitude or dialect (D. T. H. Lê, 2011). More particularly, the use of kinship terms and personal pronouns as terms of address and reference is a means for doctors and patients to express respect and maintain positive face in the Vietnamese social hierarchy (T. Q. N. Trần, 2013). Additionally, patients belong to different age groups, genders, and walks of life, requiring doctors to address and refer to them appropriately (Goffman, 1967; Iragiliati, 2012; Y. V. M. Trần, 2010; West, 1984a; see Appendix B).

Another linguistic element that needs elaborating is the questioning-responding system. Vietnamese differs from English in terms of the syntactic structures involved in forming questions and certain response tokens (B. T. Nguyễn, 2012). A description of questioning-responding is thus necessary to gain sufficient insight into the information-seeking behaviours of doctors and patients.

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[3] Terms of address are used when talking *to* someone (e.g., 'you' in 'Are you serious?'). Terms of reference are used when talking *about* someone, with two categories: self reference (e.g., 'we' in 'We are not convinced') and other reference (e.g., 'him' in 'I saw him outside the shop').

2.3.1 Main characteristics of the Vietnamese language

Given the above considerations, my point of departure for this section is a sketch of the main characteristics of the Vietnamese language. This is intended to facilitate understanding of the glosses in the translations located throughout the thesis. Without this, it will be difficult for non-Vietnamese speakers to fully grasp the translations.

Many languages are spoken in Vietnam, such as Mường, Thái, Tày, and Nùng. However, the Viet language is the communicative language of Vietnamese people and is also the official language in Vietnam. It is the mother tongue of about 85% of Viet people (also named as Kinh, the major ethnic group) residing in Vietnam (G. T. Nguyễn, 2006). Vietnamese is basically composed of three main regional dialects (i.e., Northern, Central, and Southern) which differ from one another in terms of the vocabulary and the phonetic system (Ngô & Trần, 2001). Despite these dialectal differences, Vietnamese people have little difficulty in grasping each other's meanings during communication.

In morphological terms, Vietnamese is an 'isolating' language. It has no inflectional morphology (Diệp, 2003; Ngô & Trần, 2001; Q. H. Nguyễn, 2001); that is, every word has the same form in the sentence regardless of its grammatical function. To exemplify, there are no changes in the words *tôi* ('I' or 'me') and *đuổi theo* ('chase') in (1a) and (1b) to indicate case or subject-verb agreement, respectively.

(1)　(a)　*Tôi đuổi+theo con chó*
　　　　　I　chase　　CLA　dog
　　　　'I chase the dog'

　　(b)　*Con chó đuổi+theo tôi*
　　　　　CLA　dog　chase　　me
　　　　'The dog chases me'

For this reason, the grammatical relationships in a sentence are marked by word order, while inflectional properties such as tense are marked by the addition of auxiliary words (Ngô & Trần, 2001). I exemplify the latter property with the addition of particle *đã* to indicate a past action in (2).

(2) *Tôi đã bán xe rồi*
     I   PST sell car already

'I sold my car'[4]

Another characteristic of the Vietnamese language is that each word typically consists of a single morpheme.

These characteristics have ramifications for the lexical system. Each lexical item (e.g., noun, verb, or adjective) can be optionally co-ordinated with other words (e.g., particles (PRT), empty words, adverbs, demonstratives, and so on) to identify its part of speech. These words include *ấy, những, các, một, này, kia,* or *nọ* for nouns (e.g., *xe ấy* 'that car'); *hãy, chớ, rồi,* or *xong* for verbs (e.g., *hãy cười* PRT smile 'smile'); and *lắm*, *rất,* or *quá* for adjectives (e.g., *đẹp lắm* 'very beautiful'). In the Vietnamese examples and data in this thesis, the particles without direct equivalents in English have not been translated literally but glossed by 'PRT', as exemplified above; in this case, the meaning of the particle will be captured by the translation. Additionally, there is a group of classifiers to express a wide range of categories, such as shape, fruit, plant, or inanimate thing (e.g., *hình* in *hình tròn* 'round'*, quả* in *quả quýt* 'mandarin'*, cây* in *cây nấm* 'mushroom'*,* or *ngôi* in *ngôi nhà* 'house', respectively). Vietnamese language also has honorific particles to denote politeness and respect (e.g., *dạ, ạ,* or *thưa*).

In addition, verbs and nouns can be marked for tense/aspect and number respectively. Tense markers can sometimes be used before the verb to indicate the time of actions. Particularly, *đã* or *rồi* denotes an action that took place in the past (see (2) above), *sẽ* denotes a future action, and adverbs *bây giờ, hiện tại, giờ,* or *chừ* denote a present action. Regarding aspect, *đang* indicates an action in progress, and *vừa mới* or *rồi* is used for one that has been recently completed. Likewise, plural forms can be marked by adding a plural modifier (e.g., *các, mấy,* or *những*) or a numeral (e.g., *hai* 'two', *ba* 'three', or *bốn* 'four') before the noun or pronoun (e.g., *các bạn* 'friends', or *năm bạn* 'five friends'). Notably, these tense/aspect and plural markers are optional, and depend on pragmatic factors.

The last feature to note is the word order of the Vietnamese language. Like English, Vietnamese has the basic Subject-Verb-Object order. However, according

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[4] In Vietnamese, past tense can be expressed by the particle *đã* 'PST' and/or the adverb *rồi* ('already'). *Rồi* can also be used to indicate a perfect aspect.

to Ngô (1999), the order of constituents within a noun phrase is different from English: number marker + classifier (CLA) + noun + adjective + pronoun, as in (3).

(3)   *Ba   chiếc xe   cũ   của tôi*
        three CLA   car old of   my
        'My three old cars'

Interrogative words are placed at the beginning or the end of the questions, depending on their grammatical functions (see Section 2.3.3). The interrogative particles *à, hây, hi, nhỉ, nghe,* and so on, are located at the end. The copula verbs *thì, là, mà* ('be') are sometimes absent, as exemplified in (4).

(4)   *Cô gái đó đẹp*
        CLA girl that beautiful
        'That girl is beautiful'

In sum, Vietnamese language differs from English in terms of morphology, syntax, lexis, and grammar. Therefore, when interpreting the original, glosses, and translations in all examples and data in the present study, readers are suggested to refer to this section and the 'List of abbreviations'.

2.3.2 Terms of address and reference

Vietnamese has an abundant but highly complex system of terms of address and reference. This reflects social stratification and power distance (Farris, 2012; H. V. Lương, 1990). There are more than 60 terms classified into four subsystems: personal pronouns, kinship terms, status terms, and proper names (Hồ, 1997; H. V. Lương, 1987, 1990; H. Phạm, 2001; Sidnell & Shohet, 2013; T. N. Trần, 2006). People can also communicate without using any address or reference terms – the so-called 'zero sign' (H. V. Lương, 1990; H. T. Nguyễn, 2006). Due to limitations of relevance and space, the description that follows only focuses on the terms occurring in the data presented in this thesis. I also include items relating to some dialects of the central regions of Vietnam that the participants used in this study.

2.3.2.1 Personal pronouns

Vietnamese personal pronouns are categorised on the basis of the roles and number

of interlocutors. There are various ways for address, self reference, and other reference, plus each term occurs in a singular and a plural form. The data for this study are taken from dyadic interactions, so the personal pronouns presented here are mostly singular ones.

Table 2.1

Vietnamese Personal Pronouns

Number	First person ('I/we')	Second person ('you')	Third person ('he/she/they')
Singular	*tôi* *mình, mền* - *tui*	- - *mình* -	*nó, hắn*
Plural	*mình* *chúng tui, bọn tui, tụi tui*	- *bây*	*họ, chúng nó*

In each of the singular and plural categories, all personal pronouns are arranged in descending order of formality inside each cell (e.g., *tôi* is more formal than *mình*, *mền*, or *tui*). The hyphen indicates that there is no pronoun which pairs with the one in the same row. It can be seen that the first-person singular pronoun can be preceded by several linguistic forms like *chúng, bọn,* or *tụi* ('they') to indicate the first-person plural (H. V. Lương, 1987). The first-person singular *tôi* ('I') expresses relatively neutral feeling, and is often used in formal contexts such as conferences or workplaces to express a considerable social distance between the speaker and the hearer (Ngô, 1999; H. Phạm, 2001). *Tôi* is dispreferred in informal situations among close friends or family members, or in interaction with older people or people of higher social status. It is not paired with any second-person pronouns (as indicated by '-' in Table 2.1) but paired with various kinship terms (e.g., *tôi – chị* 'I – you/older sister'), status terms (e.g., *tôi – bác sĩ* 'I – you/doctor'), or proper names (e.g., *tôi – Lan* 'I – Lan').

    Mình is used to refer to oneself ('I' or 'we') or address a second person in the singular form ('you'). *Mình* is popularly used in intimate relationships between friends or within married couples (Cooke, 1968; Farris, 2012; H. Phạm, 2001). By employing the second person *mình* ('you'), the speaker wants to establish an informal and friendly relationship with the hearer. *Mền* is from the central regions

and serves the same function as *mình*. *Tui* is from the central and southern regions. On the surface, it can be equivalent to *tôi*. However, *tui* is quite different from *tôi* as far as formality is concerned. *Tui* can be self-referred to a younger, equal, or older hearer to indicate intimacy. *Mình* ('you') is sometimes paired with *tôi* ('I') while *mền* and *tui* are not paired with any pronouns. These three pronouns are paired with various kinship terms (e.g., *mình – cậu* 'I – you', *em – mình* 'I – you', *mền – cô* 'I – you', or *tui – cậu* 'I – you'), status terms (e.g., *mình – bác sĩ* 'I – doctor' or *tui – bác sĩ* 'I – doctor'), or proper names (e.g., *mền – Lan* 'I – Lan' or *tui – Nam* 'I – Nam').

Chúng tui, bọn tui, tụi tui ('we') have their corresponding second-person pronouns *bây* ('you'), and third-person pronouns *nó, hắn* ('he, she') and *họ, chúng nó* ('they'). These pronouns are often used in informal contexts among people of the same age, or when the speaker is older than the hearer or the people being referred to. They convey three meanings: (i) indicating intimacy between the speaker and the hearer, (ii) showing contempt or disrespect, or (iii) expressing displeasure, anger, or even hostility (Bửu Khải, 1994; H. V. Lương, 1990; Ngô, 1999; H. T. Nguyễn, 2006). Regionally, *nó* is used in northern Vietnam, *tui, bây, hắn* are from the dialects of the central regions, and *tui, nó* are common in the southern areas (C. T. Hoàng, 1989).

2.3.2.2 Kinship terms

The influence of collectivist culture and Confucianism ideology on Vietnamese patriarchal family organisation (Kádár & Mills, 2011; Thompson, 1965) provides the backdrop for the usage of a vast range of kinship terms to address and refer to others. In such an inherently family-based society as Vietnam (Haines, 2006; L. D. Nguyễn, 1994; V. Q. Trần et al., 1998), the use of kinship terminologies aims to cement a strong attachment among people from wider social groups. More particularly, using kin terms, Vietnamese people tend to count others as their relatives or family members (T. N. Trần, 2006) regardless of whether they are genealogical relatives or non-relatives (Haines, 2006; Hồ, 1997; H. V. Lương, 1990). The choice of term is attuned to the age, marital status, social class, generation, degree of intimacy, gender, and the local custom (Farris, 2012; T. Đ. Huỳnh, 1989; Kádár & Mills, 2011; T. P. Lê, 2011; Sidnell & Shohet, 2013; Thompson, 1965). Table 2.2, adapted from T. Q. N. Trần (2013, p. 19), presents a comprehensive description of the kinship terms used by the participants in this study.

Table 2.2

Vietnamese Kinship Terms

First generation	*ông/bà (mệ)* ('grandfather/grandmother')
Second generation	*bác/bác* ('uncle/aunt'– parents' older sibling/his or her spouse) *cô (O) / dượng* ('aunt/uncle' – father's sister/her husband) *chú / thím* ('uncle/aunt' – father's younger brother/ his wife) *dì / dượng* ('aunt/uncle' – mother's sister/her husband) *ba / mẹ (mạ)* ('father/mother')
Third generation	*anh* ('older brother') *chị* ('older sister') *em* ('younger brother, younger sister'[term of self reference in speaking to older siblings or term of address in speaking to younger siblings]) *con* ('offspring'[term of self reference in speaking to older generations or term of address in speaking to younger generations]) *cháu* ('grandchild, niece, nephew'[term of self reference in speaking to older generations or term of address in speaking to younger generations])

Table 2.2 lays out the kinship terms in three typical generations, each ranked by seniority. The slash symbol indicates a male-female couple of the same generation. The participants in this study also used *mệ* ('grandmother'), *O* (written in upper case; 'father's younger sister'), and *mạ* ('mother'), from the dialects of the central regions. This intricate system of kin terms signifies a need for flexibility in language choice among speakers. In family relationships, a speaker can self-refer as *con* ('offspring') in communication with their parents or grandparents, and *cháu* ('grandchild, cousin, niece, or nephew') to their grandparents and their parents' siblings. In social situations, *con* is used as a self-referring term in interaction with a highly respected superior like Uncle Ho (a Vietnamese hero), a Catholic priest, a Buddhist monk, or a beloved teacher (Cooke, 1968), while *cháu* is used in talking with an older person of the first generation.

All kinship terms can be used for address, self reference or other reference. Consider the exchange between two siblings, Tuan and Trang, in (5a). The use of *chị* ('older sister') in this exchange and in (5b) is a good example of multiple uses of

kinship terms.

(5) (a) Tuan: *Chị*   *cho*   *em*   *mượn cây bút*
                older+sister please younger+brother lend   CLA   pen
        'Could you please lend me a pen?'

      Trang: *Chị*   *không có*   *bút*
              older+sister not   have pen
        'I don't have a pen'

  (b) Lan: *Chị*   *ấy*   *cao bao+nhiêu?*
              older+sister that   tall how
        'How tall is she?'

In (5a), *chị* is used as a term of address ('you') by Tuan, and as a term of self reference ('I') by Trang. In (5b), it is used as a term of other reference ('she') by Lan. However, to indicate other reference, demonstrative markers such as *ấy, đó, nớ* ('that') are often placed after the kinship terms. *Ấy, đó,* and *nớ* are neutral in meaning, like *anh ấy, anh đó, anh nớ* ('he, him'). *Nớ* is from the dialects of the central regions.

Like personal pronouns, kinship terms can be preceded by some plural indicators, like *các* or *mấy* (H. V. Lương, 1987). For each of *các* and *mấy*, the indicator can be used either with an addressee or a third-person referent in formal contexts, and can precede kin terms to address juniors (e.g., *các cháu* 'grandchildren, nieces, or nephews') or seniors (e.g., *mấy bác* 'uncles, aunts' or *các ông* 'grandfathers').

2.3.2.3 Status terms

In some situations, especially in formal ones, when the use of personal pronouns and kinship terms is inappropriate, speakers often use status terms to address others. Status terms, or titles, bespeak the hearer's profession or social status (Cooke, 1968; e.g., *bác sĩ* 'doctor', *cô/thầy giáo* 'teacher', *giám đốc* 'director', or *tổng thống* 'president'). With their implication of hierarchy or respect, these terms are rarely used to address persons of lower occupational status (Cooke, 1968; e.g., *nội trợ* 'housewife' or *hộ lý* 'hospital orderly'). Additionally, this form of address is rarely used by speakers to self-refer because Vietnamese people tend to refer to themselves

with humble terms while addressing others with high deference (T. N. Trần, 2006). In this study, the patients frequently addressed their doctors with *bác sĩ* ('doctor'), or *bác* or *cô*[5] for short. Some doctors also self-refer by using *bác* ('doctor').

2.3.2.4 Proper nouns

The participants in this study also used proper nouns as a form of address. Typical proper noun formations are plain given names (e.g., *Loan* or *Minh*), kinship term plus name (e.g., *mệ Loan* 'grandmother Loan' or *anh Minh* 'brother Minh'), or status term plus name (e.g., *bác sĩ Loan* 'doctor Loan' or *y tá Minh* 'nurse Minh'). Referring to superiors with plain given names is regarded as taboo in hierarchical societies such as Vietnam (T. Đ. Huỳnh, 1989). Plain given names are only common in intimate relationships among speakers of the same age, family members, or close friends (Cooke, 1968; H. T. Nguyễn, 2006). Kinship terms or status terms plus names are appropriate in situations that are more formal. For example, a status term preceding a full name is used as a sign of reverence (e.g., *Thủ tướng Phan Văn Khải* 'Prime Minister Phan Van Khai' or *Chủ tịch Hồ Chí Minh* 'President Ho Chi Minh').

2.3.2.5 Zero-sign address and reference

Apart from the four ways of address, self reference, and other reference above, Vietnamese people sometimes do not use any kind of reference in communication. Following H. T. Nguyễn (2006), this ellipsis mode is mostly used by superiors with inferiors in family relations, or among close friends. The use of 'zero-sign' is deemed impolite in situations when the speaker and the hearer do not know each other or are just acquaintances. In (6a) below, the mother does not employ a term of address when talking to her son, but this is acceptable in the context of an intimate relationship. If this zero-sign address is used by a doctor to a patient in a clinical setting, it may be considered unacceptable. With a term of address, the patient may feel more respected and close, as illustrated in (6b).

(6) (a) *Đau gì?*
         pain what

    'What's wrong?'

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[5] This *bác* or *cô* ('doctor') is different from the *bác* ('parents' older sibling') or *cô* ('father's sister') in the kinship-term category (see Table 2.2).

(b) *Bác   đau   gì?*
     uncle pain what

'What seems to be the trouble?'

In short, Vietnamese terms of address and reference are sophisticated and diverse. Despite this, kin terms are usually preferred in a number of contexts (H. V. Lương, 1987; Sidnell & Shohet, 2013). This was seen in this study (see Chapters 5-7). The use of kinship and status terms, on the one hand, underscores a clear and stark relationship among speakers, but on the other, attests to the stable and hierarchical nature of social relations in the system (H. V. Lương, 1990). Therefore, misuse of a kin term counts as a rule violation, and can result in negative social sanction (Sidnell & Shohet, 2013). Overall, since respect is inherent and serves as a cornerstone in Vietnamese society (Appel, 2013; T. Đ. Huỳnh, 1989), speakers should employ these terms judiciously in different situations according to their potency, and tailored to the context, their feelings, attitudes, and relationship.

2.3.3 Linguistic description of questions and responses

Few information-seeking activities pass without questions and responses (Heritage, 2010; Heritage & Clayman, 2010). This section thus speaks of the forms and functions of Vietnamese questions and responses for an insight into the doctor's elicitation and patient's disclosure of information in this study. Questions are delineated first. The responses to questions are the topic of discussion in the second part.

The normative way of forming a question is to embed an interrogative word, a modal particle, a pair of words, or the conjunction *hay* ('or') in a declarative sentence without reversing the word order (B. T. Nguyễn, 2012). The subject can be omitted in Vietnamese sentences generally, including questions, particularly in informal situations, or when a superior addresses a hearer of equal or lower social status (see (6a) above).

Based on the type of response that a question canonically elicits, Vietnamese questions can be categorised as alternative question and non-alternative question (T. Q. Lê, 2004). The former requires the hearer to select one out of two or more available propositions in reply, and the latter looks for a piece of missing information. For example, in *Bác có đau ở đây không*? ('Does it hurt here?'; see (7)

below), the hearer only says 'yes' or 'no', whereas *Bác đau ở đâu?* ('Where does it hurt?'; see (14) below) is non-alternative as it constrains the answer to a specific location of pain (e.g., head or stomach). At the syntactic level, these two categories consist of six subtypes, of which the first five are alternative and the last non-alternative (K. T. L. Nguyễn, 2010).

2.3.3.1 Alternative questions

Alternative questions include (i) 'yes/no' question using pairs of words, (ii) 'yes/no' question beginning with *có phải* and ending with *không*, (iii) 'yes/no' question ending with *phải không,* (iv) 'yes/no' question with a modal particle, and (v) alternative question with *hay* ('or'). Alternative questions can be referred to as 'polar questions'

(i) Yes/no question using pairs of words

This type of question is formed by adding a pair of words such as *có…không*, *đã…chưa*, or *còn…không* (each of which can be glossed as 'PRT … interrogative (INT)'), to a declarative sentence (K. T. L. Nguyễn, 2010). *Có…không* indicates existence, *đã…chưa* means commencement or implementation, and *còn…không* refers to continuation. Interlocutors only aim to reach minimal agreement (i.e., 'yes') or disagreement (i.e., 'no'), with or without further elaboration (Ngô, 1999). In each of (7) and (8), I exemplify the use of *có…không.*

(7)   D: *Bác   có đau ở+đây không?*
           uncle PRT hurt here   INT

      'Does it hurt here?'

      P: 'Yes/No'

(8)   D: *Có toa+thuốc   trên bàn   không?*
           PRT prescription on   table INT

      'Is there a prescription on the table?'

      P: 'Yes/No'

(ii) Yes/no question beginning with **có phải** and ending with **không**

This alternative question is headed by a single particle consisting of two words *có phải* and ends with the interrogative *không*, followed by *phải* ('yes') or *không phải* ('no') in response. This question differs from the above (see (7) and (8)) as it

conveys the speaker's *presupposition* of something they believe to be true (K. T. L. Nguyễn, 2010).

(9) D: *Có+phải bác   đau ở+đây không?*
         PRT   uncle hurt here INT

   'It hurts here, doesn't it?'

   P: 'Yes/No'

(iii) Yes/no question ending with **phải không**

This is a type of tag question formed by adding an interrogative such as *phải không*, *đúng không,* or *có không* (auxiliary verb + ['not'] + Subject) to the end of a declarative sentence (Ngô, 1999). The response is contingent on the interrogative lexical item. For instance, a question with *phải không* requires *phải* ('yes') / *không* ('no') in reply, *đúng không* is followed by *đúng* ('right/yes') / *không* ('no'), and *có không* by *có* ('yes') / *không* ('no'). This question type is also similar in meaning to the preceding one (see (9)), but conveys greater certainty (K. T. L. Nguyễn, 2010).

(10) D: *Bác   đau ở+đây phải+không?*
          uncle hurt here INT

   'You hurt here, don't you?'

   P: 'Yes/No'

(iv) Yes/no question with a modal particle

A modal particle (e.g., *à, ư, sao, nhỉ, nghe, hẩy*) is added to the end of a declarative sentence to construct this question type (Diệp, 2003; see (11)). As Ngô (1999) suggests, this question indicates a stronger belief on the part of speakers that hearers will agree with them than the previous type does (see (10)). *À*, *ư,* and *sao* register the speaker's surprise at the situation mentioned (B. T. Nguyễn, 2012), *nhỉ* denotes an assessment, a comment, or a prediction, to seek affiliation from hearers, and *nghe* signals a request with which speakers want hearers to comply. Conforming responses are *vâng/dạ* ('yes') or *không* ('no').

(11) D: *Bác   đau ở+đây à?*
          uncle hurt here INT

   'You hurt here?'

P: 'Yes/No'

(v) Alternative question with **hay** *('or')*

This type of question is constituted by the inclusion of at least two options (e.g., 'right hand' or 'left hand', as in (12) and (13)), separated by the conjunction *hay* ('or'), within a wh-question or a declarative sentence. Hearers can opt for one, all, or none of the available options.

(12) D: *Bác   đau   tay   phải hay tay   trái*?
             uncle hurt hand right or   hand left

       'Is it your right hand that hurts, or your left hand?'

       P: 'My right hand / My left hand / Both hands'

(13) D: *Bác   đau   ở+đâu, tay   phải hay tay   trái?*
             uncle hurt where   hand right or   hand left

       'Where does it hurt, your right hand or your left hand?'

       P: 'My right hand / My left hand / Both hands'

2.3.3.2 Non-alternative questions

A wh-word or phrase like *ai* ('who'), *cái gì* ('what'), *ở đâu* ('where'), *tại sao* ('why'), *khi nào* ('when'), or *cái nào* ('which') is added to a declarative sentence to form a non-alternative question. These words can be positioned at the beginning or at the end of a sentence (Ngô & Trần, 2001; B. T. Nguyễn, 2012), as illustrated by the use of *ở đâu* ('where') and *khi nào* ('when') in (14) and (15) respectively. Responses to these questions are flexible, resting on each question type and the content in question.

(14) D: *Bác   đau   ở+đâu?*
             uncle hurt where

       'Where does it hurt?'

       P: 'In my arm'

(15) P: *Khi+nào tôi uống thuốc?*
             when   I   take medication

       'When should I take the medication?'

       D: 'After a meal'

To summarise, Vietnamese has alternative and non-alternative questions. While the latter type is quite simple, the former type is more intricate, portraying the speaker's knowledge of the issue in question. This means that speakers need to choose the alternatives judiciously if they are to obtain the information that is required.

2.3.3.3 Responses to questions

General forms of responses to questions were mentioned briefly in Sections 2.3.3.1 and 2.3.3.2. Evidently, responses in Vietnamese are broadly similar to those in English. However, two special cases of responses need taking into account in order to lay a platform for the interpretation of the doctors' and patients' responses in Chapters 5-7.

The first case to note is that responding to negative 'yes/no' type interrogatives in Vietnamese runs contrary to that in English. While, in English, the response 'yes' means disagreement with the negative polar question, and 'no' implies agreement (Börjars & Burridge, 2010), the reverse situation holds in Vietnamese. In (16), the patient indicates that he is not tired by answering 'yes', whereas in English, he would say 'no (I am not tired)'.

(16) D: *Bác   không mệt   à?*
          uncle   not   tired INT?
          'You aren't tired, are you?'

     P: *Vâng*
          'Yes (I am not tired)'

If the patient says *không* ('no'), he means either 'no, I am not tired' or 'yes, I am tired'. Besides, the patient can say *có chứ* ('yes'), that is, 'Yes (I am tired)' to yield a non-alignment response. Due to such differences, readers are recommended to refer to the translation, not the gloss, when interpreting any data involving this case in the current study.

Another point worth noticing rests on the implication of *dạ* ('yes', 'OK', or 'yeah') in Vietnamese communication. Of note, while 'yes' in English enunciates agreement without any attitude of respect or disrespect (Appel, 2013), *dạ* in Vietnamese is context-based with several meanings: "I am listening", "I understand what you say", "I disagree with you but I have too much regard for you to say so to

your face" (C. Nguyễn, 1994, p. 70), "I am politely listening to you" (L. D. Nguyễn, 1994, p. 57), or "I respect what you are saying" (Appel, 2013, p. 429). As stated in Section 2.2, the prominence given to interpersonal harmony and respect in communication more or less affects people's choice of words to avoid assertiveness, disagreement, conflict, or hurt. Accordingly, people tend to reply with *dạ* to show their attentiveness even if they do not understand, or to mean 'no'. *Dạ* is not communicative by itself (Thompson, 1965) but is a polite honorific particle that signals a courteous reaction to not only a 'yes/no' interrogative but also a statement, a command, or an exclamation. *Dạ* is used in reply to an older person or a person of higher social status. By means of a nod accompanied by *dạ*, speakers wish to hold others in reverence and save face as well (T. Đ. Huỳnh, 1989; Kádár & Mills, 2011). In short, *dạ* performs three functions in this study: to show agreement with speakers, to convince hearers that the speaker's information is correct, and to indicate respect.

In closing, Vietnamese communication is partly shaped by collectivism and Confucianism, which stress interpersonal harmony, respect, and social stratification. The terms of address and reference and the questioning-responding sequence are of a high recurrence in the information-seeking practice of medical consultations. Hence, these terms are in need of proper consideration for the interpretation and analysis of doctor-patient discourse.

2.3.4 Form-function dichotomy in information-seeking acts

Mismatches between communicative function and syntactic form are a characteristic of human language generally. At the level of form, an utterance can be syntactically marked as interrogative, imperative, or declarative. In information-seeking, a question (i.e., function) is typically encoded with interrogative syntax (i.e., form). However, this does not mean that the syntactic form of an utterance always faithfully reflects its communicative function (Heritage, 2012). Some questions can be accomplished in the absence of interrogative syntax (e.g., as in a questioning declarative; Heritage & Clayman, 2010; Tracy & Robles, 2009), or this type of questioning form does not always execute an information-seeking act (e.g., as in a rhetorical question). This can be a matter of sequential position (Schegloff, 1984) or epistemic disparities between the speaker and the addressee (Heritage, 2012). In CA, function is more commonly analysed as the action a question might implement. This is not limited to whether a particular sentence solicits information or not.

According to Hayano (2012), aside from its informational content, the function of an utterance in any languages can also be realised through its prosody (i.e., the intonation contour accompanying the utterance). To demonstrate, interrogation is often marked by very high rising intonation (Levis, 1999), while affirmation often has low falling contour (Luru, 2010). However, rising intonation does not always mark an utterance as an information-seeking act (e.g., as in exclamatory sentences). Rather, the communicative function of an utterance is context- and content-based.

This form-function dichotomy is expressed in Vietnamese in particular ways. In syntactic terms, Vietnamese produces an interrogative utterance by adding a questioning word or an interrogative particle to a clause with a very high rising intonation (Luru, 2010; see Section 2.3.3). This dichotomy is illustrated in the following conversation between a doctor and a male patient extracted from the data of the current study (see (17)).[6] The first turn (line 1) is syntactically and functionally appropriate as an information-seeking question, since it is enclosed with a pair of questioning words (i.e., *có…không*) and receives an answer (line 3). When the patient says that he has drunk just a little (line 3), the doctor acknowledges and laughs (line 5).

(17)

```
1    D:→  °có uống° RUỢ:U  đồ    chi  nhiều khô:ng?
           PRT drink alcohol thing any  much   INT

           'Do you drink much alcohol or the like?'

2          (0.2)

3    P:    #dạ# có:: mà  ít
           HON yes but little

           'Yes, but just a little'

4          (0.5)

5    D:    /ừ::m (.) $/hư hừ hừ$
           mmm

           'Mmm'

6          (0.6)

7    D:→  uố:ng #mà# uống ít    làm+răng chịu nổ:i?
           drink but  drink little how      bear PRT

           'How can you bear to drink so little?'

8          (11.6)

9    D:    có  khi+mô  mà  #hắn# NẶ:NG hai cái chân mà
```

---

[6] I use Courier New font for any extracts from my data.

```
           PRT ever   COP they   heavy two CLA leg   and
10         #hắn# PHÙ:  lên nơi khô:ng?
           they  swell up  PRT INT
           'Have your legs ever become heavy and swollen up before?'
```

The doctor continues the consultation with the third utterance (line 7). Syntactically, this utterance is a question, as indicated by the question marker *làm răng* ('how'). However, it is a rhetorical question rather than an information-seeking one, as it does not seek information from the patient. This is evidenced by the absence of the patient's response after a lapse of 11.6 seconds (line 8), and the doctor issues another utterance in lines 9-10. If the doctor had needed any feedback, it seems likely that he would have repeated or paraphrased this question to coax information from the patient, instead of abruptly changing the topic to the patient's legs in lines 9-10. This rhetorical question serves as an "assertion of the opposite polarity" (Han, 2002, p. 203), implying that the patient must have drunk more than what he admitted, or, he cannot bear his low alcohol consumption. The absence of the patient's answer also denotes that both the doctor and the patient "share a prior commitment to similar, obvious, and often extreme answers" (Rohde, 2006, p. 135). They both understand what the doctor means and have the same response as well. By projecting this question right after his laugh (line 5), the doctor treats the patient's response as a joke.

Example (18) is extracted from the same consultation as above. Whereas the doctor's first utterance at line 1 is an information-seeking question, his second one (line 9) is a declarative in terms of its form. However, at the level of function, this is a repair initiation acted as a request for confirmation of a candidate understanding in view of its rising intonation contour (Đỗ, 2009; Lưu, 2010). The patient's minimally aligned answer in the next turn (line 10) also signifies that the doctor's previous proposition is a request-for-confirmation one.

(18)
```
1    D:→  anh            bị      RĂNG vô+viện    ri:?
          older+brother  suffer  what hospitalise PRT
          'What brings you to hospital?'

2         (1.1)

3    P:   *dạ:::::::::*(1.2)#hắn# mỏi+mệt #với# đau, (0.3)tê:: ↓cánh tay
          HON               it    tired  and  sick      numb CLA  arm
          'I'm tired and sick, and my arm is numb'
```

29

```
4          (0.9)

5    D:    hừ::
           mmm

           'Mmm'

6          (0.5)

7    P:    dạ
           yes

           'Yes'

8          (0.6)

9    D:→   #hắn# tê:  nguyên cánh tay rúa luô:n?=
           it    numb whole  CLA   arm PRT  PRT

           'The whole arm is numb?'

10   P     =°dạ°
           yes

           'Yes'
```

The examples (17) and (18) have demonstrated that, with specific reference to Vietnamese in each case, the communicative function and the syntactic form of an utterance do not always correspond. Informational content and prosody are used as pivotal resources in combination with the conversational context, and with the speaker's intended meaning, to formulate the information-seeking act. Thus, given the intricate relationship between function and form, we need to analyse various resources like the clinical context, the participants involved, and their interactional management rigorously in order to elucidate the doctor's and patient's communicative intent.

Up to this point, I have sketched out the main features of Vietnamese culture and language. In the next section, I present the CA paradigm.

2.4 Conversation analysis

Conversation analysis is an approach to the study of talk-in-interaction. It comes from two intellectual streams in sociology during the 1950s: Erving Goffman's micro-sociology of "the interaction order", and Harold Garfinkel's ethnomethodology (Clark & Petraki, 2016; Heritage, 1998; Liddicoat, 2007; Markee, 2000; Schegloff, 2003; D. Silverman, 1998). Other disciplines such as scholarship on oral cultures, philosophy, linguistics, ethnography, anthropology, and sociolinguistics were also deemed the influentially intellectual mainstay for CA (Maynard, 2012). The interaction order, as Goffman (1983) argued, consists of a set

of rights and obligations underpinning the workings of all societal institutions such as medicine or education. Ethno-methodology stresses how common sense views of the world are constructed through daily conversations. It "attempts to understand 'folk' (ethno) methods (methodology) for organising the world. Ethno-methodology locates these methods in the skills ('artful practices') through which people come to develop an understanding of each other and of social situations" (D. Silverman, 2001, p. 123). Drawing on ethno-methodology, Harvey Sacks, in collaboration with Emmanuel Schegloff and Gail Jefferson, developed CA during the late 1960s and early 1970s (Heritage, 1984b; Pomerantz & Fehr, 2011). Harvey Sacks' initial work speculated on how participants understand each other, how social actions are normatively organised, and how the practical work of social life is accomplished through talk in a corpus of telephone calls made to the Los Angeles suicide prevention centre. It was from this project that CA was born (Psathas, 1995).

Conversation analysis focuses on the 'what' and the 'how' of social action rather than the 'why' (Clayman & Gill, 2004; Psathas, 1995). In particular, its principal aim is to examine how speakers understand and interact with one another in verbal communication, with attention being paid to how action sequences are produced (Hutchby & Wooffitt, 1998). Put differently, it describes the procedure individuals use to create their own behaviour, or the strategies and methods individuals use to solve recurrent organisational problems of talk so that the orderliness of social action is preserved. For this reason, CA scrutinises actions, context management, and intersubjectivity (i.e., mutual understanding) simultaneously because these features are conceived of as the objects of individuals' interactions (Arminen, 2005; Drew & Heritage, 2006b).

This paradigm is predicated on four underlying assumptions: (i) interaction is autonomously structured; (ii) verbal/non-verbal features and turn-taking components are both contextually-shaped and context-renewing; (iii) the properties in (i) and (ii) exist in every detail of talk so that no details are missed as disorderly, incidental, or unrelated to the speakers' intent; and (iv) in methodological terms, reliability and validity are enhanced if the sequential structure of interaction is taken into account (Heritage & Maynard, 2006a). Specifically, the term 'context' here refers to the immediately local configuration of previous activity where an utterance is produced, and the broader environment of the activity within which that configuration is recognised to occur (Drew & Heritage, 1992). By context-renewing, each utterance

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itself creates the context for the next action so that the latter can be understood. Accordingly, the production and interpretation of an utterance are based on the social context, and on the position of the utterance in the sequential organisation of talk. Overall, these assumptions emerge from the underlying conception that sequencing is the backbone of CA, and thus participants' demographics (i.e., age, gender, and social status) and their specific motivation or psychology have nothing to do with their talk (Heritage & Maynard, 2006a).

At the outset, CA was developed as a tool for studying the organisational structure of mundane conversations (i.e., ones that are not confined to a particular context, or restricted to performing a particular task). Later, it expanded to a wide spectrum of institutional contexts, including news interviews (e.g., Clayman, 1988; Greatbatch, 1988), education (e.g., McHoul, 1978; Mehan, 1979), courtrooms (e.g., Atkinson & Drew, 1979), and politics (e.g., Heritage & Greatbatch, 1986), and became the predominant methodology for social interaction studies in sociology (Drew & Heritage, 2006b). Therefore, as an off-shoot of ethno-methodology, CA takes an inductively 'bottom-up' approach. It focuses extensively on mapping meaning and context onto the sequence and examining the micro verbal exchanges that individuals routinely perform during their interaction with one another, such as action formation, adjacency pairs, turn-taking, repair, or topic organisation (Clark & Petraki, 2016; O'Keeffe, 2006).

Conversation analysis has proved itself an effective method for analysing institutional interactions, as it can provide a comprehensive examination of the talk. Such effectiveness forms good grounds for the adoption of CA as the analytical method for the present study.

2.5 Chapter conclusion

Chapter 2 has provided a theoretical backdrop for the study of Vietnamese medical discourse. The institutional and socio-cultural context as well as the Vietnamese language lies at the core of the analysis of doctor-patient interaction. Similarly, the cultural terms and form-function dichotomy are basic sources of reference for the interpretation of Vietnamese doctor-patient talk generally, and for the negotiation of meaning during information-seeking activities in Vietnamese medical discourse in particular.

Before embarking on the empirical part of study, the thesis now shifts to a

review of previous research in doctor-patient interaction, highlighting the indispensability of information-seeking activities in medical discourse.

Chapter 3

Literature review

3.0 Introduction

Chapter 3 reviews the literature on doctor-patient interaction in order to map out a context for the present study. It begins with a broad overview of research on doctor-patient interaction in general (Section 3.1), and then characterises the structural properties of a typical medical visit (Section 3.2). This framework is necessary background for the review of previous research on information-seeking activities in Section 3.3, and for the review of medical research in the Vietnamese context in Section 3.4. Section 3.5 discusses the limitations of previous research in these two areas, followed by the research questions (Section 3.6).

3.1 Overview of research on doctor-patient interaction

Doctor-patient interactions have been well researched in the Western world but not in the Vietnamese medical context. As health lies at the core of wellbeing, it is unsurprising that medical talk should have captured various researchers' attention, ranging from doctors, linguists, sociologists and psychologists, through to anthropologists (West, 1984a). A plethora of studies has been done using CA or non-CA methods to explicate its nature (e.g., Finset, 2014; Ha & Longnecker, 2010; Heritage & Maynard, 2006b; Laidsaar-Powell et al., 2013; Ong et al., 1995; Paul, Metcalfe, Stirling, Wilson, & Hodgson, 2014; Roter & Hall, 2004). Different aspects of medical discourse have undergone analytic scrutiny, such as phases of the visits (Robinson, 2003; White, 2011), patient satisfaction (Brédart et al., 2005; Sorenson, Malakouti, Brown, & Koo, 2015), patient participation in consultations (Cegala & Post, 2009; Kearney, Robinson, & Venetis, 2015), medical expertise (Kendall, 2004; Norman, Eva, Brooks, & Hamstra, 2006), and demographic variable influence on communication (Callahan et al., 2000; De Laender, 2011; Hall, Gulbrandsen, & Dahl, 2014; Roter et al., 2014).

With respect to this study, studies on doctor-patient communication, including Vietnamese-related ones, have fallen into two categories (Cordella, 2001, 2004; N. T. H. Phạm, 2014; Ohtaki, Ohtaki, & Fetters, 2003; Wodak, 2006): medical-sociological perspectives and linguistic perspectives. I will now elaborate on both of

these to demonstrate how the present study fits into the larger framework of research on doctor-patient interaction.

Research following the medical-sociological perspective has been mainly carried out in the fields of social sciences and medicine (Cordella, 2001, 2004) using the research methods other than CA. Studies in this area are normally grounded in a sociological framework. They are oriented toward the organisation of talk and thus focus largely on the general features of communication as well as on the outcome of medical consultations (Cordella, 2004; Ha & Longnecker, 2010; Korsch, Gozzi, & Francis, 1968; Ley, 1988; Roter & Hall, 2006). These studies specifically evaluate the effectiveness of a model of medical consultation, or, more particularly, measure the patient's satisfaction with and adherence to the treatment recommendation. On this basis, several models have been proposed for improving doctor-patient communication, such as Heron's (1976) six-category intervention analysis, Cohen-Cole's (1991) three-function approach, or Charles, Gafni, and Whelan's (1997) shared decision-making model. These models aim to improve the understanding of the interpersonal relationship between a health professional and a client, and address both the physical condition and the emotional needs of clients. This contributes to more effective doctor-patient communication.

Whereas medical-sociological studies offer a general portrayal of medical visits, they do not examine how participants deploy their interactional and discursive strategies in the negotiation of meaning during consultations. However, this limitation is the strength of linguistic research which uses either CA or non-CA methods. Such studies are interested in how participants use their communicative strategies to accomplish a social action (Cordella, 2004). These studies examine participants' linguistic organisations, such as their use of questions, responses, interruptions, topic shifts, word choice, or doctor's use of medical terms, as these linguistic tokens lie at the heart of any interaction (e.g., Deppermann & Spranz-Fogasy, 2011; Gill & Maynard, 2006). They found that participants deployed discourse in order to achieve specific aims (e.g., asymmetrical power, or elicitation of information; Černy, 2010a, 2010b, 2010c; West, 1984a).

Another dominant theme of linguistic research is the investigation of the effect of participants' age, gender, or social background on their communication behaviour (e.g., Ainsworth-Vaughn, 1992, 1994; Buller & Buller, 1987; Domingo, 2010; Hein & Wodak, 1987; Ishikawa & Yamazaki, 2005; Roter & Hall, 1992, 2006; Swartz,

2014; Van Ryn & Burke, 2000). These studies have found that: (i) female doctors tend to engage in longer, more patient-centered talk than males ('patient-centred talk' and/or 'shared decision-making communication' refer to a reciprocal two-way flow of communication with the shared management over the talk between participants to reach unanimity over therapeutic decisions), (ii) female patients talk more and give more information than male patients, (iii) young patients involve themselves more enthusiastically in medical consultations than old ones, and (iv) patients from higher social classes are more active communicators than those from lower classes.

As an approach that aims to closely analyse interactions, CA began to permeate health communication research in the early 1980s through the studies of Ten Have (1980), Atkinson and Heath (1981), Heath (1982), Frankel and Beckman (1982), and West (1983, 1984a, 1984b). This research can be classified into three streams: (i) doctor-patient interaction, (ii) patient-patient or patient-paraprofessional interaction, and (iii) doctor-doctor interaction (Gill & Roberts, 2012). Conversation analysis was initially applied to primary care consultations between doctors and patients (Gill & Roberts, 2012) before expanding its application to the gamut of activities associated with various medical disciplines and various medical/health settings, ranging from surgery (e.g., Mondada, 2003; White, 2011) and dentistry (e.g., Marks-Haack, 1992) to AIDS counselling (e.g., Peräkylä, 1995). In the primary care setting, a large body of literature has documented various aspects of the doctor-patient interaction, such as problem presentation (e.g., Halkowski, 2006; Heritage & Robinson, 2006a, 2006b; Pomerantz, 2002; Robinson, 2006), history-taking (e.g., Boyd & Heritage, 2006; Heritage, 2010), physical examination (e.g., Heath, 2006), diagnosis delivery (e.g., Heath, 1992; Maynard, 1992; Peräkylä, 2002, 2006a, 2006b), and treatment recommendation (e.g., Stivers, 2006; Stivers & Barnes, 2017).

In summary, it is apparent that doctor-patient interaction has been widely researched, but most of this has been conducted in Western contexts. Grounded on the sociological stance that the responsibility of medical doctors is to return patients to a state of physical well-being, medical-sociological studies accentuate the influences of communication on the outcomes of the consultation. The studies focusing on the linguistic perspectives of doctor-patient interaction go into every detail of the talk to see how such outcomes are interactionally produced and accomplished. Medical consultations are characterised by interactions between doctors and patients, thus a granular analysis of their interactions can highlight how

both participants manage their talk to achieve a specific action. This analysis can explicate the shared understandings between both participants, which can inform the medical outcomes and improve the medical communication.

To this point, the focus has been on the research literature related to doctor-patient interaction in general. Doctor-patient interaction includes various activities such as diagnosis delivery and treatment recommendation, of which information-seeking practice is an elemental step. It is important, therefore, to overview the structure of a medical visit to locate the information-seeking activities in the whole visit.

3.2 Structural properties of a medical visit

This section describes the normative framework of a medical visit. This does not, however, necessarily mean that the structure of the Vietnamese medical visits in the present study follows what is described below, nor that the information-seeking stages have the same locations. My purpose is to provide general background to the analysis of information-seeking in the present study (see Chapters 5-7).

Numerous attempts have been made over the past 40 years to depict a canonical structure schema of a medical consultation. Byrne and Long (1976) led this with their six-phase model drawn from an investigation of over 2,000 general practice consultations (made up of first, follow-up, and routine visits) in Great Britain. What they found was an interactionally interlocking sequence of activities, the functions of which were jointly adhered to by both doctors and patients: "(i) greeting and relating, (ii) discovering the reasons for attendance, (iii) conducting a verbal or physical examination or both, (iv) a consideration of the condition, (v) detailing further treatment, and (vi) terminating the interview" (p. 132).

The six-phase model of Byrne and Long (1976) can be illustrated as follows. The 'greeting and relating' phase is characterised by such ritual words as 'Hello' or 'You are Mrs Baker?' to preface the consultation. In 'discovering the reason for attendance', doctors elicit the patient's foremost concern with broad opening questions like 'What brings you in today?' for first visit, or 'No better?' for follow-up or routine visits. In responding, patients may say, for example, 'I have a backache'. Based on the patient's presented problem, doctors may ask further questions (the so-called 'conducting a verbal or physical examination or both') about symptoms to elicit data on the temporal context, patient's medical history, or family

illness history. Upon gleaning sufficient data from various sources (i.e., verbal and physical examinations, referrals, medical records, or prescriptions), doctors give either provisional (e.g., 'It seems that you have a virus') or confirmed diagnosis (e.g., 'You have a virus'). The diagnosis thus informs 'detailing further treatment', such as by giving a set of instructions to take certain medication, or arranging a follow-up visit or a referral (Pauwels, 1995). The consultation is usually terminated in the form of leave-taking.

As a stepping stone in a medical visit (J. Silverman et al., 2013), information-seeking activities tend to be spread over the whole consultation rather than be circumscribed to the initial stages. Byrne and Long (1976) asserted that information-seeking could happen after diagnosis or the treatment phase, yet it frequently fell into the second and third phases (i.e., discovering the reasons for attendance, and conducting a verbal or physical examination or both). However, where it is located varies visit by visit.

3.3 Research on information-seeking activities in a medical consultation

Having established that the medical consultation chiefly revolves around the doctor seeking information about patients' health status (Heritage, 2010), initial studies tended to look at the conduct of doctors through the way they structured the consultations. Coulthard and Ashby (1975, 1976) carried out groundbreaking sociolinguistic studies into the linguistic features of doctor-patient consultations that stressed the structures of doctors' information-seeking behaviour. Of 24 audiotaped consultations between general practitioners (GP) or consultants and their patients, Coulthard and Ashby observed the recurrence of exchanges which doctors used to (i) elicit information, (ii) direct patients to follow a command or instruction, or (iii) provide patients with some information. These exchanges occurred throughout different stages of the consultations. Coulthard and Ashby maintained that virtually all information-seeking exchanges were initiated by doctors rather than by patients, and that the interaction was asymmetrically organised as doctors led the discourse right from the onset of the consultations.

Around the same time, by examining over 2,000 audiotaped consultations, Byrne and Long (1976) delineated the various stages of a medical visit (see Section

3.2), and examined doctors' consulting styles within the continuum of patient-centred and doctor-centred medicine. The study revealed that doctor-centred styles dominated up to two-thirds of all consultations, and that a majority of doctors adopted an information-seeking style to control the interaction, while patient-initiated questions only occurred at the end of the consultation. The information-seeking style means that doctors carry out the consultation using mostly questions to coax information from patients.

The studies above show that information-seeking activities have long been explored in literature. However, information-seeking activities did not lie at the heart of these studies. Rather, these studies looked closely at the linguistic description (e.g., Coulthard & Ashby, 1975, 1976) or the structural framework (e.g., Byrne & Long, 1976) of the medical consultation. Later studies, which are examined below, focused specific attention on information-seeking itself.

3.3.1 Doctor's information-seeking behaviour

Doctor-patient interaction can be carried out in various forms, such as, written documentation, referrals, prescriptions, or online consultations. In providing the disciplinary context for the present study, I limit the following review to information-seeking studies that have focused on face-to-face talk within clinics, hospitals, family practices, and office situations. Since the amount of research on information-seeking using CA methods in general practice, and for adult patients specifically, is limited, I have expanded this review to include the following: other disciplines such as paediatrics and geriatrics; interactions in clinical professional workshops; doctors of all kinds (e.g., doctors in training as well as graduated doctors); dyadic or triadic interactions; all visit types (i.e., first, follow-up, or routine visit); and both CA and non-CA studies.

The current literature on doctor information-seeking has centred mainly around either doctor interviewing-styles or doctor elicitation strategies, and the effects of those strategies on patients' disclosure of information. The studies on interviewing styles have provided a general picture of doctor interviewing behaviours (both verbal and non-verbal), while those on elicitation strategies have had a microscopic view of one strategy (e.g., questioning or fishing).

3.3.1.1 Interviewing styles

Studies on doctor interviewing styles have focused on the doctor's performance throughout the consultation to find out how they elicit information from patients. Their interviewing styles have been found to substantially shape patients' disclosure of information (e.g., Beckman & Frankel, 1984; Marvel, Epstein, Flowers, & Beckman, 1999). For instance, doctor interruption to patient presentation of their health concerns has been found to influence the amount of information obtained, as shown by Beckman and Frankel (1984). With the aim of examining the doctor's role in eliciting patient concerns at the outset of the medical consultation, Beckman and Frankel looked at 74 audiotaped medical visits involving in-training residents and elderly chronic patients at a university medical practice. Using a quantitative coding method to transcribe the consultations, the study found that only 17 out of 74 patients (23%) had the opportunity to complete their presentation of concerns, while 51 (69%) of patient openings were truncated by doctor-initiated questions. Doctors often interrupted patient presentation using closed-ended questions, resulting in doctors leading the discourse right from the beginning of the consultation. This interruption prevented patients from presenting a full spectrum of their concerns. Only one interrupted patient went on to complete their problem presentation despite the interruption. Another finding was that there was no doctor elicitation of problem presentation in six follow-up visits (8%).

Marvel et al. (1999) expanded upon Beckman and Frankel's (1984) study using a larger sample of 264 audiotaped medical visits between 29 trained[7] or experienced doctors and 264 patients in North America. Their main objective was to investigate how family doctors in various settings elicited patient concerns. Adopting the quantitative coding method developed by Beckman and Frankel, Marvel et al. sought to determine if there was any relationship between different communication variables, whether there was a difference between completed and non-completed visits on patients' lengths of utterances, and assess the relationship between the doctor's training status (i.e., experienced doctors vs. fellowship-trained doctors) and completed agenda setting. Similar to Beckman and Frankel, Marvel et al. found that only a small number of patients completed their presentation of concerns (28%). Doctors often curtailed patients' initial presentation of their problems after a mean of

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[7] 'Trained doctors' are family doctors who conduct post-residency fellowship training.

23.1 seconds, which often resulted in patients' producing incomplete descriptions of their concerns. Consequently, doctors were unable to gather potentially important patient data. Noticeably, twice as many trained doctors as experienced doctors allowed patients to complete their presentation of their concerns (44% vs. 22%).

Replicating the Beckman and Frankel (1984) and Marvel et al. (1999) methodology, Dyche and Swiderski (2005) explored the association between doctor interruptions and their accuracy in determining patient problems. They analysed 70 audiotaped medical consultations at a community-based ambulatory clinic in the USA. Exit interviews with both doctors and patients were also conducted in order to assess doctor accuracy in identifying patient problems. Results showed that 26% of patients could present their problems without interruptions, whereas 37% were impacted by the doctor's premature interruptions prior to completion; the remaining 37% had no doctor elicitation of problem within the first five minutes. Analysis of the exit interviews revealed no significant differences in doctor accuracy in identifying patients' problems between the interrupted and non-interrupted cases. In the consultations with no doctor elicitation of patient problem presentation, the doctor's understanding of patient concerns was significantly reduced.

Whereas doctor interviewing styles in the above three studies appeared to inhibit patients' disclosure of data, Wissow, Roter, and Wilson (1994) explored styles that stimulated disclosure. To investigate how paediatricians elicited sensitive information about potential risks to a child's further physical and emotional development, Wissow et al. carried out a cross-sectional analysis of 234 audiotaped primary care visits between paediatric residents in training, and child patients accompanied by mothers or guardians, at a paediatric primary care clinic in the USA. They employed a modified version of the Roter Interaction Analysis System (RIAS) to code the three-way discourse involving the child, parent, and paediatrician. The Roter Interaction Analysis System is a method for coding medical communication devised by Debra Roter in collaboration with Susan Larson in the late 1970s. It encompasses socio-emotional and task-focused grouping under 39 categories as a means of characterising doctor and patient verbal and non-verbal behaviours. Wissow et al. identified three consulting techniques associated with parent disclosure of information: (i) questions about psychosocial issues, (ii) supportive statements, and (iii) sympathetic and attentive listening. These three techniques assisted in the parents' disclosure of information about parent medical or emotional impairment,

family trouble, use of physical punishment, and negative child behaviour.

Another study by Roter and Hall (1987) in the USA examined the correlation between doctor interviewing strategies and the medical information obtained from patients. Recruiting 43 primary care practitioners and two trained patient simulators (i.e., role-play patients) with chronic bronchitis and emphysema, these clinical consultations were audiotaped and analysed using the content analysis criteria developed by Wang et al. (1979) to score doctor proficiency and patient disclosure of information. The content analysis criteria were developed by the expert judgement of a panel of pulmonary physicians. In general, Roter and Hall discovered that doctors elicited a little more than 50% of the clinical information considered important according to the criteria. Doctors' use of questions (particularly open questions) and patient education (especially information concerning diagnosis, cause, and prevention) were significantly associated with patient presentation of their concerns.

In a similar vein, Takemura et al. (2007) examined the relationships between doctor use of five specific consulting techniques and the amount of information regarding the patient's chief physical complaints. The techniques included facilitation, open-to-closed cone, summarisation, open-ended questions, and surveying problems. Facilitation, such as nodding one's head or using backchannels, encourages patients to continue with their talk. An open-to-closed cone is characterised by open questions for a nondirective approach, then narrowing down gradually using closed ones, in order to focus on a specific diagnostic hypothesis. In summarisation, doctors restate main ideas from the information obtained thus far in order to demonstrate their understanding of what patients have said, and to keep the conversational floor. Open-ended questions encourage patients to voice their information using their own terms through their personal experiences. Surveying patient problem is used when doctors scan a full range of patient concerns at the end of the medical consultation, with such questions as 'What else is bothering you?', to ensure that no concerns have been left unaddressed. Takemura et al. videotaped 315 GP first visits between medical students, family medicine residents, or attending doctors, and 315 patients suffering from common diseases at a university medical practice in Japan. They developed the Takemura Medical Interview Rating Scale specifically for this study to assess the doctor's use of particular consulting behaviours and to gauge the amount of information obtained. Of the five techniques above, the first three (i.e., facilitation, open-to-closed cone, and summarisation) were

found by Takemura et al. to exhibit a positive relationship with the amount of information obtained.

While each of the above studies explored only one aspect of interviewing style (i.e., either promoting or inhibiting patient disclosure), Maguire, Faulkner, Booth, Elliott, and Hillier (1996) investigated both aspects. Their study involved audio-and-video recordings of consultations between 206 health professionals and an unspecified number of simulated patients in a series of 12 workshops on medical communication in The United Kingdom. Each health professional was asked to interview two different patients before and after the workshops to elicit patient concerns. An utterance-by-utterance analysis was carried out to rate the syntax, function, meaning, and emotional level of each utterance, and to examine the relationship between health professional's particular interviewing behaviours and patient disclosure of significant information (i.e., pain severity, anxiety about illness or loneliness). The study showed that five strategies were positively linked to patient disclosure of information. These were: asking open directive questions, concentrating on and elaborating psychological topics, making empathic statements, summarising, and making educated guesses. In addition, patient disclosure was precluded by the doctor asking leading questions (e.g., 'You have taken chemotherapy in your stride, haven't you?'), concentrating on and elaborating physical aspects, and turning to advice and reassurance practice. Inhibitory behaviours were found to be three times more frequent in the consultations held before the workshops, which in turn indicated that the workshops improved medical communication.

Recently, Goto and Takemura (2016) reported the same finding as that of Maguire et al. (1996) in a study on the association between doctor interview-skills and patient verbal presentation of anxiety feelings or depression. This study was conducted at a university-based hospital in Japan using 159 patients, and 159 family doctors, family medicine residents, or medical students. The researchers used a Medical Interview Evaluation System (Takemura et al., 2007) to evaluate doctor medical interview skills, and an Emotional Information Check Sheet defined by themselves to clarify the indications of anxiety feelings or depression. The link between the doctor's skills and patient's disclosure of feelings in 159 videotaped first consultations was then analysed. Like Maguire et al. (1996), Goto and Takemura reported that interview skills such as: using open questions, reflecting (i.e., doctors state their own perceptions based on their observation of patients), asking patients

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about illness, and legitimising (i.e., doctor's acceptance and validation of the patient's emotional experience) resulted in a higher amount of anxiety disclosure than closed or focused questions. Goto and Takemura also found that respectful communication strategies promoted depressive disclosure on the part of the patient, whilst survey questions (i.e., ones raised after summarisation to see whether the patient has other concerns or not) did not.

The above studies have identified some common interviewing styles that health professionals, in different specialisations and cultural settings, adopt to elicit information from patients. These are supportive and/or empathic statements, reflection or educated guesses, summarisation, and facilitation or legitimisation. As far as the content of consultations are concerned, doctor's discussions or questions about psychosocial issues induced a lot more patient disclosure than those about physical issues. The styles inhibiting patient disclosure have also been identified. They include premature interruptions or redirection of patient utterances, surveying problems, and closed and focused questions. There are some interviewing styles that either promoted or inhibited patient disclosure, like the use of open-ended questions.

This section has been concerned with research on doctor interviewing styles. It is notable that these studies did not analyse the doctor's choice of interviewing style when eliciting *all* types of information relating to the patient's concerns. Rather, they just focused on some types of information, such as problem presentation, sensitive information, medical information, chief physical concerns, significant information, or feelings of anxiety and/or depression. As Bickley and Szilagyi (2013) claim, doctors should elicit as much information as possible: the more information they obtain, the better placed they are to make a diagnosis and a treatment recommendation.

Moreover, these studies used coding to transcribe consultations, and then evaluated the doctor's elicitation of information quantitatively based on their interviewing style. Although the use of a coding system enables researchers to analyse a large number of consultations and can cover a wide range of contexts (Heritage & Maynard, 2006a, 2006b; Roter & Larson, 2002), it cannot by itself account for how doctors deploy these interviewing strategies in discourse. The reason is that coding analyses information by classifying events and using statistical tests without transcribing interactions (Greene, Adelman, Charon, & Hoffman, 1986). As a result, coding disregards the context of each information-seeking act

(e.g., whether an information-seeking act occurs in relationship with another act; Heritage & Maynard, 2006a). This is a potential problem because, if a given information-seeking act is removed from its context, the social actions associated with this act will be difficult to analyse; for instance, we will not be able to decide whether a question is used to request information, make a suggestion, give advice, or request action. Moreover, the relationship between these social actions and others throughout the consultation will be difficult to determine (Heritage & Greatbatch, 1989). In turn, if the social actions expressed by information-seeking acts are unclear, we will not be able to analyse doctor interviewing styles effectively or, on a broader level, identify patterns of talk in actual consultations readily.

Lastly, none of these studies examined patient information disclosure behaviours in tandem with doctor interviewing styles. Given that the doctor's information-seeking practice inevitably shapes, and is in turn shaped by, the patient's disclosure strategies (Claramita, 2012; Robinson & Heritage, 2006), it is crucial to examine the interaction between both interlocutors, as this will enable us to see how they respond to any interactional challenges that may arise during medical consultations (Gill & Roberts, 2012). In so doing, we can highlight the specific content and context of information-seeking activities across various stages of a medical consultation. In addition, the interlocutors' interactional actions and interactional patterns are also identified. This gives us a better view of the doctor's elicitation and the patient's disclosure of information, which in turn can deepen our understanding of the information-seeking activities that unfold during the medical consultation as a whole.

3.3.1.2 Elicitation strategies

In examining the doctor's information-seeking activities, some researchers have focused on one or two specific elicitation strategies. My review of the literature highlighted two strategies that constantly recurred in literature. They were questioning and a fishing device. Most of these studies used CA to analyse data.

(i) Questioning

Doctors' questions are integral to the medical consultation, constituting a fundamental method for engaging patients (Ainsworth-Vaughn, 1994; Heritage, 2010; Holst, 2010; Robinson, 2006; Ten Have, 1991). They have been explored in

the literature around three strands: (i) the functions of questioning; (ii) the syntactic structures used in questioning; and (iii) how doctors question patients.

The first strand looks at the functions of doctor questioning. In his study of Japanese patient-centred consultations, Holst (2010) audiorecorded 72 GP first visits at the outpatient section of a university-based hospital and analysed these using a CA approach plus quantitative analysis. Holst categorised doctor questions as eliciting new information (i.e., information that has not yet been discussed in this medical visit) or calling for confirmation (i.e., questions to check if doctors understand what patients have just said). He found that doctors used probing and follow-up questions to elicit new information, and used summarising, echoing, and leading questions to seek confirmation. In another study on doctors' communicative strategies in conveying empathy and trust, Černý (2010b) also observed different functions of doctor questioning in 50 GP consultations. Combining quantitative and qualitative analysis, Černý found that doctors used questions mostly to obtain new information (64%), and less frequently to seek confirmation (15%), clarification (7%), commitment (6%), agreement (5%), or for repetition (3%). In summary, the functions of doctor-questioning activities can be grouped into two clusters: seeking new information and checking known information.

The second strand looks at the syntactic structures of doctor questioning. In their work on the design of doctor questions during history-taking, Boyd and Heritage (2006) discussed two types of question: open questions (i.e., wh-question) and closed questions (i.e., yes/no, declarative, alternative, and tag questions). The syntactic form taken by a question can shape or constrain patient answers. For instance, closed questions tend to limit patient contributions, since patients answer only 'yes' or 'no'. Meanwhile, wh-questions allow patients some discretion to answer in their own terms and allow them to construct a narrative from their life-world experience. Similar findings were found in the study of Li, Koehn, Desroches, Yum, and Deagle (2007) about the associations between doctor communication and patient satisfaction. Li et al. also observed that the more closed questions doctors asked, the less satisfied patients became with doctors.

The last strand examines how doctors question patients. West (1983, 1984a) investigated the asymmetrical aspect of medical consultations by using quantitative analysis and CA to analyse 21 videotaped GP consultations at a family practice centre in the USA. She found that these GPs failed to evoke full responses from

patients when linking a series of questions within one utterance, or when utilising multiple choice questions. This is because doctors did not give an opportunity for patients to answer when linking a series of questions, or multiple choice questions were seeking a choice rather than further elaboration. Incomplete answers also occurred when doctors asked the next question while patients were answering the last question. The consequence of such question deployment is that patient information can be missed.

The influence of doctors' question deployment on patient disclosure of information was also a focus of Cordella's (2004) study on doctors' different voices (e.g., the doctor voice, the educator voice, and the fellow human voice). Cordella audiotaped 22 GP follow-up consultations at the outpatient clinic of a university-based hospital in Chile. Using a combination of interactional sociolinguistics and ethnographic approaches, Cordella identified five categories of questions in search of information (QIS) used by doctors: (i) QIS one (only one question asked), (ii) QIS chain (a string of questions), (iii) QIS multiple choice (questions consisting of more than one option), (iv) QIS recycling/repetition, and (v) QIS plus summary. Similar to West (1983), Cordella also found that Chilean patients did not provide full answers to QIS chain and QIS multiple choices. Rather, they only addressed the last question or option. Addressing the importance of doctor questions, Ciubotaraşu-Pricop (2013) suggested that open questions should be preferred to closed questions. Syntactically, closed questions require recipients to show only agreement or disagreement, without any further elaboration. This is potentially problematic as some questions may not have the exact answer the recipient wants to give. Further, Ciubotaraşu-Pricop argued that questions should be expressed in words that patients could understand without chaining two questions together. Chain and multiple choice questions cover more than one point of inquiry and thus may confuse patients, leading them to concentrate on the last inquiry heard (Swartz, 2014). This may account for the absence of patient complete answers to QIS chain and QIS multiple choice in West (1983, 1984a) and Cordella (2004).

Besides studies focusing on one certain strand, several researchers have focused on both question formats and question functions within the one study. Harres (1998) audiotaped 29 GP consultations in her study of Australian doctor's use of modal tag questions (expressing uncertainty) and affective tag questions (expressing positive politeness) as a control and involvement strategy. She used the criteria

developed by the Community Medicine Program at the Monash Medical Centre to code the consultations. Harres found that GPs used tag questions as both control and involvement strategies to perform three functions: (i) eliciting information, (ii) summarising and confirming information, and (iii) expressing empathy and providing positive feedback. Using CA with 13 audiotaped first medical visits in Germany, Deppermann and Spranz-Fogasy (2011) studied how doctor questions reflect their understanding of patient prior turns. They observed that doctors used wh-questions and yes/no questions to elicit topics, and declarative questions to check already achieved understandings and close topics. There are three practices of declarative questions: repeating, paraphrasing, and explicating declarative questions. As Deppermann and Spranz-Fogasy observed, doctors used the repeating practice to confirm their understanding of a certain topic presented by patients, and to draw further elaboration on already presented information. Paraphrasing was used to reaffirm and summarise patient statements from the doctor's perspective. Explicative declarative questions enabled doctors not only to check their understanding of patients' talk, but also to introduce a new topic and show doctors' empathy for patients' psychological distress.

In line with the research above, Heritage and Robinson (2006b) used CA to explore the relationship between doctor opening questions and patient presentation of concerns. They examined 302 videotaped medical visits, followed by pre- and post-visit questionnaires, in the USA. Five question types that were used to initiate patient problem presentation were identified. These were: (i) open questions and 'tell me about X' format used as a general inquiry, (ii) closed questions to request (dis)confirmation related to the patient's medical problems (e.g., 'So you're sick today, huh?'), (iii) closed questions to request (dis)confirmation of concrete symptoms (e.g., 'You slipped and fell four weeks ago?'), (iv) 'How are you?' questions to elicit general assessments rather than presentations of concern, and (v) closed questions to take medical history (e.g., 'You have any fever?'). Heritage and Robinson found that the first question type was the most common one, accounting for more than 60% of questions compared with 27% of requests for confirmation (i.e., second and third types). This first question type also engendered longer problem presentations from patients than confirmatory questions (27.1 seconds and 12 seconds respectively). This implies that open questions and 'tell me about X' format can, to some extent, elicit more information than closed question types.

In another study on doctors' design of questions to elicit patient presenting concerns, Robinson (2006) used CA to analyse 182 audio-and-video recordings of primary care visits in the USA and Britain. He discovered three different question formats to elicit patient medical concerns: (i) open or closed questions for dealing with new concerns (i.e., ones presented for the first time to a specific doctor or clinic), (ii) open questions for eliciting follow-up concerns (i.e., ones already dealt with in previous visits and now followed up for the ongoing management of treatment), and (iii) open or closed questions for indexing chronic-routine concerns (i.e., ones dealt with on a regular basis). Like Heritage and Robinson (2006b), Robinson also noted that doctors used the 'How are you?' question to call for an evaluation of the patient's general state of being, instead of focusing on the patient's institutionally relevant concerns.

Heritage and Robinson (2011) examined doctors' uses of 'some' or 'any' in their problem presentation elicitors in order to encourage patients to reveal their unmet concerns. They recruited 20 doctors and 220 patients to primary care visits in the USA. Adopting quantitative analysis to 220 visits, pre-visit and post-visit survey of the patients, Heritage and Robinson found that doctors' uses of 'some' was more significantly effective than their uses of 'any' regarding reducing the number of patients leaving the visit with an unmet concern. In addition, the length of 'some' visits was shorter than that of 'any' visits, this is because 'some' elicitors collected additional concerns early in the visits, they allowed doctors to manage time effectively, thus reducing the visit length.

To reiterate, doctors use different question types to perform different information-seeking functions. Open questions pursue new information, whilst declarative questions seek confirmation. Some other types can be used to perform both functions, such as tag questions or yes/no questions. Overall, the three doctor questioning strands complement and relate to one another (Heritage & Robinson, 2006b; J. Silverman et al., 2013). More particularly, the functional category and the mode of doctor-questioning deployment are often examined in association with their syntactic structures. In the same vein, by looking into the structures of questions, researchers can see how questions function or how they are uttered in discourse (Hayano, 2012).

(ii) Fishing device

Another strategy for eliciting information is 'fishing', a term coined by Pomerantz (1980) to characterise a technique that doctors use to collect information when they have limited access to patients' health condition prior to consultations taking place. Swartz (2014) called this technique 'confrontation' or 'interpretation'. Doctors can offer a candidate answer (i.e., giving information in their answers to seek further information), report an experience of their own, or make an assertion about the patient's health based on their observation or inference. In response to these attempts to 'fish', patients may proffer more specific information. Bergmann (1992) and Swartz (2014) remarked that doctor assertions invited patients to formulate private problems, disclose personal feelings, talk about their troubles, or clarify discrepancies in the history. Bergmann suggested two devices that doctors may use in making assertions for this purpose. The first was pointing out the specifically derivative character of their knowledge by referring to a third party (e.g., "Doctor Hollmann told me something like you were running across the street not so completely dressed or something like that"; p. 29), or describing this knowledge as a product of their observation or impression (e.g., "I can see from your face that the mood apparently is not bad"; p. 33). The second was pointing out the uncertain character of their knowledge (e.g., The uncertain character is expressed in the words 'somehow' and 'seems' in this example: "Somehow also a behaviour seems to have occurred where you really acted a little bit peculiar"; p. 29).

This section has reviewed two elicitation strategies that doctors use to extract information from patients. Questioning in particular has been the subject of much research. While this strategy seems to be a rather direct eliciting device, fishing is somewhat indirect. Although fishing does not clearly elicit information, it can trigger patient disclosure.

Overall, it can be seen that each of the studies in this section looked at only one elicitation strategy (i.e., either questioning or fishing). However, a single focus does not always mean that this is the only strategy that doctors use. In reality, doctors employ other strategies to elicit information as well, such as summarisation, listening, or facilitative responses (J. Silverman et al., 2013). Moreover, they are likely to switch strategies within the consultation. Hence, if we look at all strategies within the one study, we can attain a better understanding of doctors' information-

seeking activities.

Another point to note is that these studies were restricted to the two initial stages of the medical consultation: problem presentation and history-taking. In fact, information-seeking does not stop after the patient presents their concerns, but typically continues until the treatment recommendation. Previous studies have shown that information elicitation can occur throughout the consultation (e.g., Byrne & Long, 1976; Coulthard & Ashby, 1975, 1976). For an optimal treatment plan to be developed, doctors need to elicit *all* required information, and this may occur throughout the whole of the consultation, not just at the start. In other words, if we examine information-seeking activities throughout the whole consultation, the patterns of talk can be identified more accurately.

Third, most of these studies did not examine how questions or fishing were used to elicit information. For example, questioning in Holst's (2010) study was a means to assess how doctors created and sustained patient-centred consultations, whilst the use of questions to evaluate patient satisfaction with doctors was the theme of Li et al. (2007). Put differently, questions and fishing were regarded in these studies not as strategies for eliciting information, but as means towards other ends. Consequently, it is not clear how doctors deployed them to obtain needed information interactionally.

Lastly, most of these studies tended to ignore patient information disclosure behaviours as well. As discussed in Section 3.3.1.1, if these behaviours are not examined in tandem with doctor elicitation strategies, our understanding of information-seeking activities may suffer.

Hitherto, I have gone through the research on doctor's information-seeking behaviours. The next section examines the patient's disclosure of information.

3.3.2 Patient's disclosure strategies

If the doctor perspective has long been examined, it was not until the early part of the twenty-first century that the patient perspective became a focus of sustained research attention. Similar to doctors, patients also formulate their own strategies when providing information. These are shaped by and, in turn, shape, patient role identities and local projects (Pomerantz, 2002). Aside from supplying answers to doctors' elicitors, patients also avail themselves of opportunities to intervene in the doctor's talk so as to volunteer information about themselves, or to make their own tentative

diagnosis. My review of literature shows that this appears to be the only kind of patients' disclosure strategy that has been documented in the literature.

3.3.2.1 Supplying answers to doctors' elicitors

The most common practice of patient's information disclosure is to answer doctors' elicitors. Several CA studies have been done on how patients supplying information in response to doctors' problem presentation elicitors. For example, Halkowski (2006) looked at how patients constructed their presentation in the form of a narrative of symptom discovery. From data of 25 videotaped primary care outpatient visits in the USA, Halkowski identified two features of patient naratives: (i) 'at first I thought 'X'' report, and (ii) the 'sequences of noticings'. In adopting these devices in their narratives, patients show themselves as reasonably seeking care for their problems.

In the same vein, Heritage and Robinson (2006a) investigated how primary care patients in the USA gave their reasons for seeking medical care, that is, claiming the doctorability of their problem. Examining 300 videotaped visits, Heritage and Robinson found that patients tended to frame their problem presentation according to 'known' and 'unknown' problems. 'Known' problems referred to medical conditions which patients experienced previously while 'unknown' problems were beyond patient previous experience. In presenting these problems, patients deployed three practices: (i) making diagnostic claims, (ii) invoking the opinions of a third party, and (iii) making 'trouble-resistant' claims.

To recap, previous studies on patient supplying answers to doctors' questions tended to focus on the strategies patients adopted in their presentation to establish the doctorability of their problem. Based on their own problems, patients used such techniques as narratives of symptom discovery, diagnostic claims, invocation of the opinions of a third party, and trouble-resistant claims.

3.3.2.2 Information volunteering

One function of patient expanded answers is to proffer further details to assist doctors in making an accurate diagnosis and treatment plan. Stivers and Heritage (2001) employed CA to examine a single primary care consultation at a hospital in the USA. They found that, during history-taking, the patient expanded her answers as part of her responses to the doctor's questions and, in doing so, volunteered more

information than was asked for. The expansions appeared to work to address the difficulties in producing definite answers to some questions, interpolate further details into the patient's estimation or judgement, and pre-empt negative inferences (by the doctor) arising from her unelaborated answers. Stivers and Heritage also came across two cases not elicited by a doctor's question, or serving as an expansion on the answer: pre-emptive expansions and narrative expansions.

In Japan, Nishizaka (2011) studied how pregnant patients voiced their concerns during problem presentation. He applied CA to 42 videorecorded regular prenatal check-ups at private clinics, midwife houses, and general hospitals. Like Stivers and Heritage (2001), Nishizaka discovered that patients expanded their answers in response to health professionals' routine questions. Their expansions in this study served two aims. The first was to append another piece of problem-indicative information to the answers in response to health professionals' routine questions. The second aim was to raise a possible concern by clarifying, modifying, or justifying the answers.

In brief, patients strategically expanded their answers to volunteer further information for various purposes. These expanded answers occurred as responses to health providers' questions, or spontaneously without any constraints by health providers' questions.

3.3.2.3 Self-diagnosis

Another function of patient expansions is to articulate their lay diagnosis for confirmation/disconfirmation from health professionals. Stivers (2002b) carried out a CA study on how parents' use of candidate diagnosis to pursue an antibiotic prescription from paediatricians. She analysed 360 audio-and-video-recorded acute care consultations at six private clinics in the USA. Her analysis revealed two practices that parents adopted to present their child's problems: symptoms-only presentation and candidate diagnosis presentation (e.g., 'We were thinking she has an ear infection because she's been having pain'). The former practice primarily looked for paediatricians' medical evaluations of the children, whereas the latter sought treatment given that diagnosis has already been available. In response to the former presentation, paediatricians either shifted directly to an investigation of the patient's problem, or presented their next diagnoses in the form of formulated announcements. The candidate diagnosis presentation was responded to either immediately or during

the diagnosis stage.

The two problem presentation practices found in Stivers (2002b) were also found in Ijäs-Kallio, Ruusuvuori, and Peräkylä's (2010) CA study on doctor orientations to different types of patient problem presentations. Ijäs-Kallio et al. studied 86 videorecorded primary care consultations at nine health centres in Finland. Besides the two practices of symptoms-only (35%) and candidate diagnosis (29%), they also identified two other presentation practices: diagnosis-implicative symptom description (24%; e.g., 'He complained about his ear yesterday'), and candidate diagnosis as background information (12%; e.g., 'I've had sinus infections and now I have a feeling that this right side is totally congested'). Ijäs-Kallio et al. noticed that doctors addressed patient candidate-diagnosis when they either received the problem presentation or delivered the diagnosis.

In her CA study on how patients handle their lay diagnosis in clinical talk, Pomerantz (2002) recognised that patients presented their lay diagnosis in two strategic ways. These were fully-endorsed diagnosis and uncertain diagnosis. The former was exposed with no uncertainty markers (e.g., 'I think' or 'might'), whilst the latter was delivered reluctantly within two equally possible explanations (i.e., either confirmation or disconfirmation). For instance, patients prefer confirmation in 'I think I might have allergies', and disconfirmation in 'Should I be concerned more about my heart?'.

In sum, there are several strategies that patients can adopt to present their concerns. The common ones are either presenting their concerns only, or expanding their answers to give supporting details, make a diagnosis, or justify their answers. However, we can see that each of these studies tended to analyse one specific type of patient information, that is, answers to doctors' questions, volunteered information or self-diagnosis. Apart from these two types, patients also disclose other types of information in response to doctor elicitation. This disclosure practice lies at the heart of every medical consultation. In addition, most of these studies examined only the two initial stages of the medical consultation: problem presentation and history-taking. Given that doctor elicitation occurs throughout the consultation, and that patient disclosure is initiated by doctor elicitation (Claramita, 2012; Robinson & Heritage, 2006), patients may disclose further information during the physical examination, diagnosis, and treatment. As we shall see in Chapters 6 and 7, the

participating patients continued to disclose information during the physical examination and treatment, and even after the consultation had ended. Lastly, these studies did not examine patient disclosure of information in tandem with doctor information-seeking behaviours. As a result, they did not illuminate the interactional dynamic of patient disclosure practice in discourse.

I now turn my attention to the review of the literature that has specifically focused on Vietnamese medical discourse, as this cultural context is the research locus of the present study.

3.4 Research on medical discourse in the cultural context of Vietnam

Research on Vietnamese doctor-patient discourse has been conducted in the overseas context (e.g., Vietnamese doctor-patient consultations in the USA) or in the domestic context (e.g., Vietnamese participants residing in Vietnam).

3.4.1 Overseas context

There is a body of research that has focused on how Vietnamese immigrants communicate in English with non-Vietnamese doctors. For instance, G. T. Nguyễn et al. (2007) conducted semi-structured interviews with 20 immigrants undergoing cancer screening in the USA and asked them about their experiences of talking with medical professionals about this screening. Using grounded theory to analyse the data, G. T. Nguyễn et al. identified three emerging themes. First, patients had difficulties communicating because of the language barrier given that most had limited English proficiency. Second, patients differed in their attitude toward screening and discussing this with their doctors. Third, other communication problems were identified, such as difficulties in communicating because of patient shyness. Overall, most participants seemed dissatisfied with doctor-patient communication about cancer even when doctors shared patients' ethno-linguistic background. Dissatisfaction notwithstanding, patients appeared to trust doctor information, yet rarely engaged doctors in discussions about cancer. This means that patients were not involved actively in their consultations; maintaining a passive role in their communication with doctors. As a result, patients may not have disclosed some information that was critical to diagnosis and treatment.

Such inhibited and compliant behaviour was also observed by K. Trần (2009)

in her study on the conversational constraints that patients experienced in communicating with GPs. Using a thematic analysis approach to examine 12 semi-structured interviews with immigrants in the USA, K. Trần noticed that virtually all patients claimed to have only spoken when doctors asked them to. She reported that their behaviour was motivated by a desire to minimise any imposition on doctor autonomy, avoid hurting doctor feelings, or reduce the likelihood of any negative evaluation of their low English proficiency by doctors. This communication style accounted for the patient's lack of assertiveness and low participation in consultations. Consequently, this may impact on doctor elicitation of patient major concerns.

Another study by Fancher et al. (2010) on patient communication about depression with their doctor found evidence of similar patient communication-patterns. Fancher et al. conducted semi-structured interviews with 11 patients and their family members from 30 to 65 years old living in the USA. The data were then analysed using a grounded-theory approach. The authors concluded that these patients rarely expressed their concerns directly unless asked, and that their descriptions of their depressive symptoms were often constrained by stigma and 'face', social functioning and the family role, healthcare beliefs, and language and culture. In other words, if doctors did not ask, patients would not disclose their own concerns, queries, or expectation of the treatment method. As a consequence, doctors were unable to obtain potential important information from patients.

In conclusion, studies in overseas context have suggested that there is a lack of assertiveness on the part of patients when communicating with doctors. This inhibited communication style limits their disclosure of information, which in turn, influences the medical outcomes.

3.4.2 Domestic context

There have been only two studies in the domestic context to date that I could locate. One study by T. Đ. Nguyễn (2012) documented the characteristics of doctor-patient communication at a hospital in Hanoi with the participation of 80 doctors and 51 patients. All participants completed questionnaires, which provided the main data for the study, then follow-up interviews with 10 doctors and 7 patients were conducted to support the findings from questionnaires. In addition, observations were also made to evaluate the verbal and non-verbal behaviours of doctors and patients. In

particular, T. Đ. Nguyễn observed one conversation among patients, one consultation between a doctor and a patient, and one consultation between a doctor and the researcher himself (as a patient). T. Đ. Nguyễn used statistical inferences to analyse the data from questionnaires, but he did not mention how interviews or observations were analysed. His findings showed that doctors adopted several communication strategies when examining patients during medical consultations. These were: controlling style, democracy style, and freedom style. 'Controlling style' meant that doctors led consultations and gave few opportunities for patients to raise their concerns, while by using 'freedom style', doctors encouraged patients to join the talk in an active manner. 'Democracy style' referred to a mode of doctor-patient communication predicated on shared decision-making. Shared decision-making was a reciprocal two-way flow of communication in which patients were allowed to decide the treatment method of their choice. According to T. Đ. Nguyễn, of all the three consulting styles, 'democracy style' was most frequently used.

In another study, N. T. H. Phạm (2014) investigated GP's initiation of information-seeking activities. The study was restricted to examining the GP's first question to elicit the patient's presenting concerns. It recruited 6 GPs and 118 outpatients at a large hospital in central Vietnam. The data came from 118 audiorecorded first visits and 6 follow-up interviews with GPs. Using pragmatics to analyse the data, N. T. H. Phạm concluded that the GP's design of information-seeking elicitors was culturally and linguistically bound. In particular, GPs often used the lexical unit *đau* ('pain' or 'illness') to refer to the reasons why patients came to hospital, and to seek symptoms of the pain and patient general health condition. However, sometimes patients did not interpret *đau* ('pain' or 'illness') as what doctors meant. Consequently, they did not disclose the required information, and doctors might have to ask more questions than usual. This may influence the accuracy of information to be elicited, which, in turn, influences doctor diagnosis and treatment recommendation. In addition, the consultation took more time.

In closing, studies in the domestic context have shown that Vietnamese doctors frequently adopted a democracy consulting style during medical consultations. Moreover, their elicitation of problem presentation was constrained by Vietnamese linguistic features and cultural norms.

This section has unearthed several shortcomings in contemporary studies conducted

in the medical context of Vietnam. Firstly, the number of studies in this cultural context is still limited. This is especially true of the domestic context, with only two studies done so far (i.e., T. Đ. Nguyễn, 2012 and N. T. H. Phạm, 2014).

Secondly, while studies in overseas contexts focused on patients' communication, those in the domestic context looked at doctors' communication. In other words, no studies examined both doctors and patients within the same study. Medical consultations are characterised by the interaction between doctor and patient; therefore, if we focus on only one participant in the interaction, we necessarily overlook the dynamics of the interaction between both participants. As a result, it may be difficult to understand fully how each participant manages their discourse to achieve a specific social action.

Thirdly, information-seeking activities have not been deeply researched in the Vietnamese context. N. T. H. Phạm's (2014) study is limited in scope, as it was concerned with doctor design of elicitors to initiate the information-seeking process. It did not look at the whole consultation. Based on patients' presentation of concerns, doctors may also need to ask additional questions to expand the patient's health story in order to inform their treatment plan; yet, this issue has not been addressed in the research literature in the Vietnamese cultural context to date. More to the point, as the patient's disclosure was left unexplored in N. T. H. Phạm (2014), this study did not shed light on how doctors and patients interacted during information-seeking activities.

Last but not least, most studies (except N. T. H. Phạm, 2014) used interviews or questionnaires as their main data collection approach. While interviews and questionnaires can be valuable for obtaining information about personal experiences and perceptions (Holstein & Gurium, 2004; White, 2011), they do not show the actual conduct of doctors and patients. For example, we could not see how the doctor's consulting style was used in practice, or how the patient's passive role was enacted in real interactions. Hence, the research findings may not reflect what happens in real-world consultations.

3.5 Limitations of previous research on doctor-patient interaction

This section summarises the limitations of research on doctor-patient

communication. In contemporary studies dealing with doctor interviewing styles, three shortcomings have been identified: (i) these studies only examined some types of information, for example, sensitive information, physical concerns, anxiety feelings, or depression; (ii) these studies based their data analysis on quantitative approaches to coded interactions; and (iii) these studies did not look at patient information disclosure behaviours in tandem with doctor interviewing styles.

In contemporary research focusing on doctor elicitation strategies, there are four shortcomings: (i) each of these studies examined only one elicitation strategy, while, in actual practice, a doctor may have to mobilise different strategies to elicit different types of information in different stages of a medical consultation; (ii) these studies only investigated two stages of a medical consultation: problem presentation and history-taking; (iii) most of these studies did not examine how questions or fishing devices were used to elicit information in medical discourse; and (iv) most of these studies did not examine doctor elicitation strategies in tandem with patient information disclosure behaviours.

Studies on the patient's disclosure strategies have exhibited three shortcomings: (i) these studies did not examine all types of information that patients disclosed to doctors. Rather, each of these studies focused on one specific type of information; (ii) most of these studies did not look at the patient's disclosure during the whole consultation, but restricted their coverage to the history-taking or the problem presentation phases; and (iii) doctor information-seeking behaviours were not examined.

Likewise, four shortcomings have also been identified in the extant literature on Vietnamese medical discourse, regardless of whether the study was conducted in Vietnam or elsewhere. First, within research dealing with medical discourse generally, this context has so far garnered relatively little attention. Given that institutional and cultural differences have an impact on doctor-patient communication (Aarons, 2005; Fisher & Groce, 1990; Fisher & Todd, 1986; Schouten & Meeuwesen, 2006; Street, 2003; Wodak, 2002), it would be a mistake to assume that the findings obtained from Western studies will necessarily be representative of medical communication in general. This creates a need for more research to be done in other cultural contexts, not least the Vietnamese one. Second, within the limited body of work carried out in this context, little research has examined both doctors and patients within the same study. Third, information-

seeking activities in medical consultations have not been researched in depth. Fourth, the analysis of doctor-patient communication in most of these studies was not based on real interactions between doctors and patients.

In light of the above, the present study has two overarching objectives: (i) to address the limitations of research on information-seeking activities in medical communication generally, and (ii) to add to research on medical discourse in the cultural context of Vietnam. Accordingly, this study aims to explicate doctor elicitation and patient disclosure of all types of information throughout the whole medical consultation in the institutional context of Vietnamese public hospitals, using CA as the main analytical method.

3.6 Research questions

The research questions that this study seeks to address are:

1. How do doctors elicit and seek information from their patients in medical consultations?

2. How do patients disclose information to their doctors in medical consultations?

3. What information is elicited and sought by doctors, and disclosed by patients, in medical consultations?[8]

Moreover, each of these questions is being posed within the Vietnamese medical context specifically, that is, by examining medical interactions undertaken in the Vietnamese language by Vietnamese participants. In addition, the current study is situated within the domestic context of Vietnam only.

3.7 Chapter conclusion

Chapter 3 has reviewed literature on information-seeking activities in doctor-patient interaction, and literature on medical discourse in the Vietnamese context. Although doctor-patient interaction has been well researched, there are gaps in the area of information-seeking activities and in Vietnamese medical discourse. The review has established a space for framing the three research questions to be answered in the

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[8] I combine doctors' sought information and patients' disclosed information in one question because, from my data set, most of the information sought by the doctor is identical to the information disclosed by the patient (e.g., symptom, problem presentation, duration, cause, and so on). This combination avoids repetition and, more importantly, can highlight some minor differences between doctors' sought information and patients' disclosed information.

present study. Having reviewed the literature, the thesis now moves to describing the methodology adopted to answer the research questions.

Chapter 4

Methodology

4.0 Introduction

Chapter 4 elaborates the methodological underpinnings that are used in this thesis to explicate the information-seeking practices in Vietnamese medical interactions. The research context, participants, types of medical consultation, and ethical considerations are described in Sections 4.1, 4.2, 4.3, and 4.4 respectively. The next four sections present the materials (Section 4.5), data collection procedure (Section 4.6), data transcription (Section 4.7), and data analysis (Section 4.8).

4.1 Research context

This study was carried out at two provincial public hospitals in Vietnam. As linguistic behaviours in general may be sensitive to the institutional context, the research sites where this study has taken place may have influenced the doctor-patient interaction. Therefore, the ethnography of the research sites is made explicit to illuminate the characteristics of the research hospitals and the routine of typical patient visits. Prior to ethnographically describing the two research sites, the Vietnamese healthcare system and healthcare beliefs will be explored.

4.1.1 Vietnamese healthcare system and healthcare beliefs

The healthcare system in Vietnam offers two healthcare plans: public and private. This system has some similarities but also some differences to Western healthcare systems. The public healthcare system comprises four basic levels, which are set out in Figure 4.1. Each level comprises hospitals or health centres. The research sites for the current study are two provincial specialised hospitals (i.e., the second level).
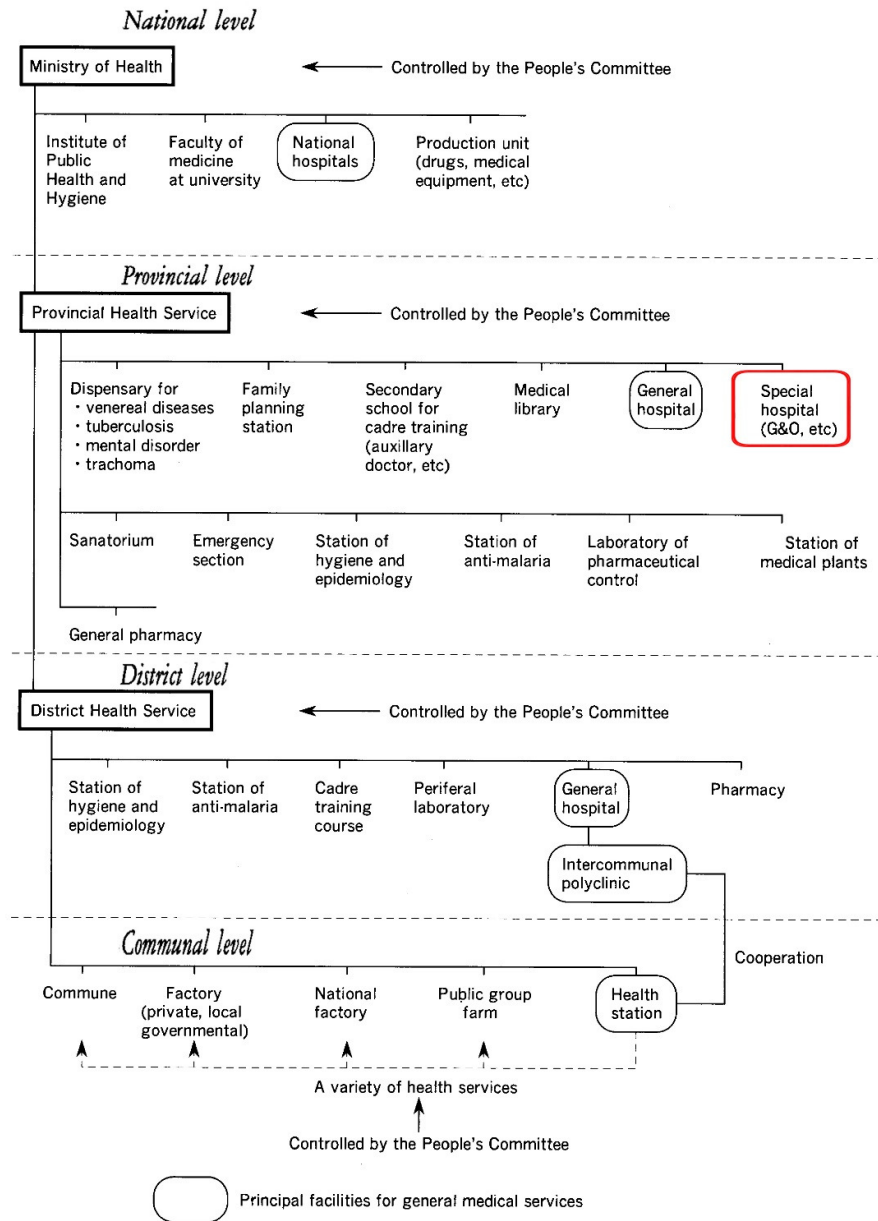
Figure 4.1. Structure of the public healthcare system in Vietnam

Note. Reprinted from Matsuda (1997)

The consulting procedure at public hospitals is partly shaped by the health insurance scheme. "Luật sửa đổi, bổ sung một số điều của luật Bảo hiểm y tế 2014 [Law of Amendment, Supplement to Articles in Health Insurance Law 2014]" (2014; henceforth, 'LASAHIL') stipulates that compulsory health insurance must be applied to all households as of January 1st, 2015. Even so, only 82.01% of Vietnamese population had joined the health insurance scheme by July 2017 (Hà Linh, 2017).

This scheme of compulsory health insurance aims to ensure equity and foster well-being for the whole society. In principle, most health insurance holders are required to register for primary healthcare at a local medical centre in their community (i.e., the district or communal level in Figure 4.1) or at a private medical centre. Therefore, health workers at communal or district health centres are the first contact point for insured patients. Only some specially insured participants, approved by the Minister of Health (e.g., people with great contributions to the Revolution, the elderly aged 85 or more, children under six years old, retired cadres, war veterans, administrative civil servants, and provincial social organisations), are allowed to register for primary healthcare insurance at provincial or national health centres.

Despite such a stipulation, a substantial number of patients, especially patients with serious illnesses or emergency cases, have tended to skip the communal medical centres to go directly to the often overcrowded provincial or central hospitals. This is often because of the low quality of services at the local level, plus general patient mistrust towards the professional ability of staff at local-level institutions (Priwitzer, 2012). This treatment desire of patients, along with an absence of prior notice or appointments (N. T. H. Phạm, 2014; Xuân Tình, 2014), may prevent doctors from setting a good schedule for the number of patients to be seen in a day (Claramita, 2012). This results in an overloaded situation at public hospitals, where doctors often face a heavy workload. Sometimes they have to see more patients than expected, which means that they may have to cut down on the amount of time spent on each consultation (H. T. T. Trương, personal communication, June 20th, 2016).

The overcrowded situation at public hospitals has moved some patients toward non-state health institutions for quicker service (Hort et al., 2011). Therefore, private medical centres have boomed to meet the increasing health demand of patients. However, patient decisions to attend private medical centres are subject to their monthly income since their health insurance does not cover the hospital fees, except at some approved centres (LASAHIL, 2014). If patients wish to skip their insurance-registered health centres to attend ones at a higher level within the public system, they have to obtain a hospital transfer permit from some stipulated medical centres (either private or public ones), otherwise, they incur full fees. Normally, patients with healthcare insurance are covered from 80% to 100% of the total fees, subject to their career status, age, and illnesses (LASAHIL, 2014).

The overcrowded situation in public hospitals is, to some extent, derived from

Vietnamese healthcare beliefs. Firstly, like patients in the Southeast Asian region, Vietnamese still place a high value on traditional medicine[9] (Woerdenbag et al., 2012). Secondly, they do not have regular medical check-ups (N. T. H. Phạm, 2014, P. X. Trần, 2013). Thirdly, they seem to favour imported Western medication, especially that from developed countries, over local ones. Fourthly, they often apply the treatment experiences of others to their own health (S. P. Huỳnh, 2016). Finally, they tend to change doctors unless there is recovery within a few days (Thu Hà, 2015).

These healthcare beliefs are reflected in Vietnamese treatment habits. When contracting illnesses, Vietnamese often take one or more of the following treatments as a first aid (Gordon, Evans, Shapiro, & Đặng, 2009; Thu Hà, 2015): (i) trying herbal medicine (e.g., *xông hơi* 'herbal steam therapy', which penetrates the body with steam), (ii) doing coin rubbing (i.e., a coin is rubbed firmly and repeatedly on the painful area until blood appears under the skin), (iii) taking medication verbally prescribed by a pharmacist at a drugstore, and (iv) looking up the treatment on the internet. In other words, people often come to see doctors as a last resort or in severe circumstances (N. T. H. Phạm, 2014; P. X. Trần, 2013). These healthcare beliefs and treatment habits may partly influence the patients' medical history narratives that doctors take during medical consultations.

4.1.2 Hospitals

This study was carried out at two provincial specialised hospitals in Vietnam under the direct management of the Provincial Health Service. Both hospitals specialise in traditional medicine and rehabilitation. These hospitals, rather than the ones specialising in Western medicine, were chosen as traditional medicine is characteristic of Vietnamese medicine. The two hospitals are the same in terms of treatment plans, objectives, and services, and as such, I will not describe each separately. Both hospitals (henceforth coded as 'Hospital A' and 'Hospital B') attract a large number of patients from neighbouring districts every day, aside from local patients in the community. They receive patients with or without medical insurance, and the latter have to pay full fees. In my informal talk with an administrator of

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[9] Traditional medicine, using herbal medicine, physiotherapy, or acupuncture to cure disease, is a kind of therapy developed out of the experiences indigenous to different cultures. Traditional medicine differs from Western medicine: the former uses plants and plant materials to treat diseases while the latter is based on the use of drugs and surgery.

Hospital B on June 13th, 2016, he reported that the hospital is not allowed to receive directly any patients whose medical insurance is not registered at this hospital, but only the transferred ones. Consequently, their patients' illnesses are mostly serious when patients reach this hospital. An administrator of Hospital A said on June 14th, 2016 that most of the patients of this hospital are transferred from the health centres at lower levels (i.e., district or communal health centres). Nevertheless, the number of patients at this hospital is low, as the lower-level health centres are capable of delivering good treatment to patients. Consequently, they do not often need transferring.

Despite their medium size, both hospitals serve as teaching and training centres for medical students at postgraduate, undergraduate, junior college, and secondary levels from the Medical University and Medical College in the region. These hospitals are also practice training centres for health professionals from neighbouring provinces and apprentices in the region, to sharpen their professional skills and gain experience. At these hospitals, there is no need for patients to book appointments in advance in order to see a GP or a specialist. A referral letter is not required unless the patient's medical fee is covered by medical insurance.

Data for this study were collected at the Consultation and General Practice Units of the two hospitals. The main duties of these units are to undertake medical care and perform on-demand examination and treatment. Any serious cases beyond their treatment ability will be transferred to hospitals at a higher level (i.e., a national hospital; see Figure 4.1). The majority of patients at the two hospitals suffer from chronic pain, requiring long-term treatment. Therefore, they often return for a follow-up treatment course after a point in time.

4.1.3 Consulting rooms, wards, and the consulting procedure

This study recorded the medical consultations in the consulting rooms of both hospitals, and also in the wards of Hospital B. This section thus describes these rooms and the consulting procedure.

When a patient comes to hospital, they are examined by a doctor in the consulting room (some of the consultations in this study were recorded in this room; see Figure 4.2). The doctor then classifies the patient as a consulting patient, an inpatient or an outpatient. The inpatients and outpatients move to the inpatient or outpatient wards respectively (some of the consultations in this study were recorded

in these rooms), where they are examined again by an attending doctor on the same day. They then take a three-week or two-week treatment course respectively. Consulting patients neither stay in nor regularly return to the hospital, but visit doctors once only for medical treatment. Their illnesses are thus often minor. H. T. T. Trương (personal communication, June 20th, 2016) revealed that doctors in the consulting rooms often conduct a more thorough examination on consulting patients than on the other two types (i.e., inpatients and outpatients), as the latter are examined again by other doctors during their hospitalisation. Once inpatients and outpatients are classified and assigned to specific wards, doctors at different units take charge of their long-term treatment. These doctors then attend to their patients on a daily basis to monitor their illnesses.
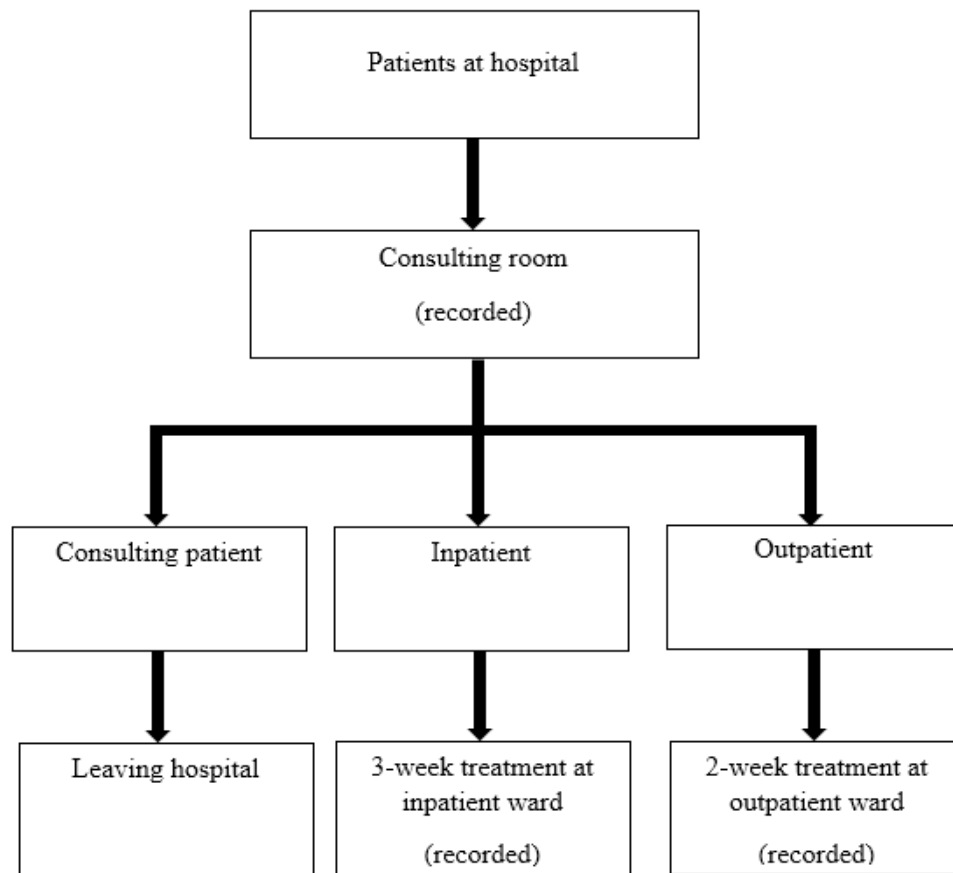
Figure 4.2. Consulting procedure

The consulting rooms of the two hospitals are arranged differently. Hospital A has only one consulting room for two doctors working at the same time (see Figure 4.3). The consulting room is air-conditioned, and appropriately furnished. The nurse

sits near the door (chair 3) to receive patients. Chairs 1 and 2 are for the same doctor-patient dyad, and chairs 4 and 5 for another dyad. The patient's companion (if any) sits on the consulting bed or stands beside the patient. Two doctors usually conduct medical consultations at the same time. However, during the data collection period of this present study, only one doctor worked at a time (seated at chair 1). Two audio recorders were put on the table in front of the dyad.

wash basin	filing cabinet	scale	X-ray film viewer

consulting bed

2   3

1   7   doctor's table   5

door

4

6

window

1. doctor 1's chair	5. patient 2's chair
2. patient 1's chair	6. patient-listing board
3. nurse's chair	7. audio-recorders
4. doctor 2's chair	
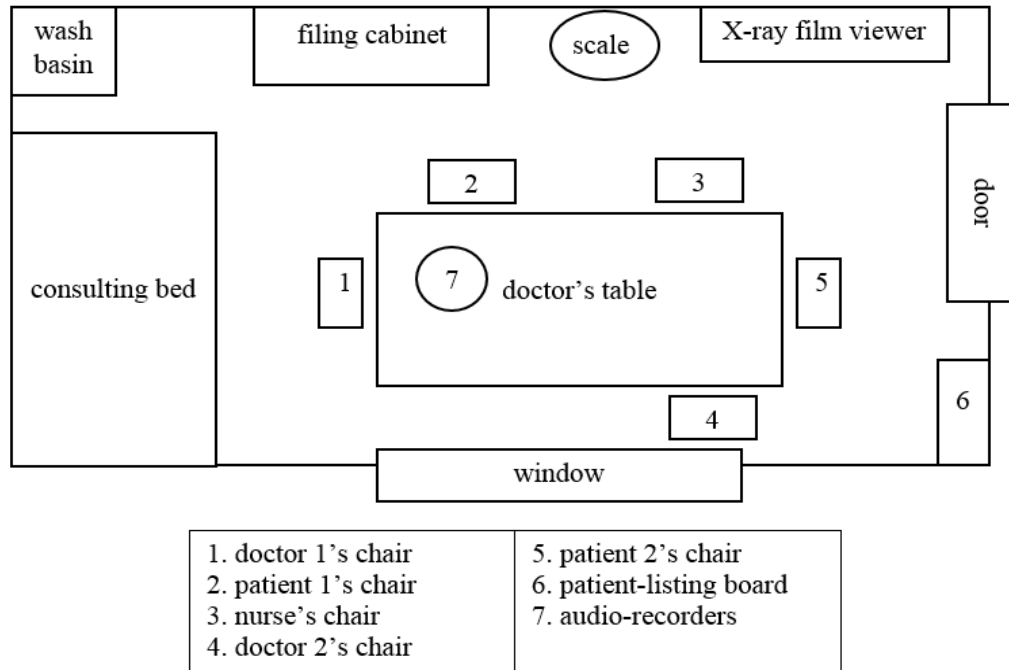
Figure 4.3. Consulting room at Hospital A

Upon arriving at the hospital, patients present their medical insurance card to a female nurse seated at chair 3, and then take a seat in the corridor (used as a waiting area) for their turn. The examination is often carried out on a 'first come first served' basis, but priority is given to patients aged 75 or more. As soon as patients enter the consulting room, the nurse elicits their demographic information and contact details for their medical records. She is not involved in the doctor-patient talk during the consultation. At the close of the consultation, she often weighs patients, measures their height, and directs them to the relevant offices.

Hospital B has two separate consulting rooms for two different doctors: a female doctor examining female patients, and a male doctor examining male patients. If one doctor is not available, the other examines all patients, regardless of their

gender. The female room and male room are depicted in Figures 4.4 and 4.5. Any companions have to stand beside the patient during the consultation. The audio recorders were placed on the table near both participants. The two consulting rooms are adjacent to each other, separated by a movable glass wall. These two rooms both face the reception area, which is located in the same area, but also separated by a movable glass wall.

| 1. patient's chair | 3. coat stand (for doctor's coat) |
| 2. doctor's chair | 4. audio-recorders |
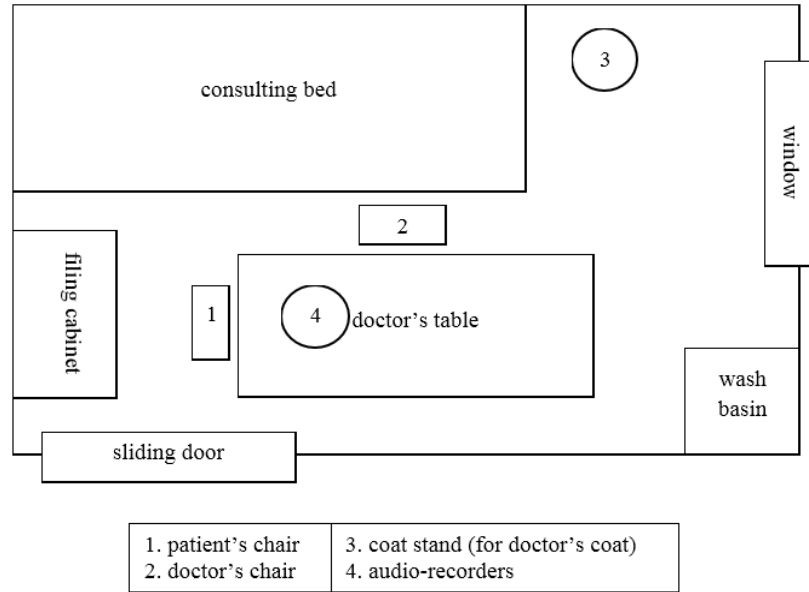
Figure 4.4. Female consulting room at Hospital B

| 1. doctor's chair | 3. apprentice's chair |
| 2. patient's chair | 4. audio-recorders |
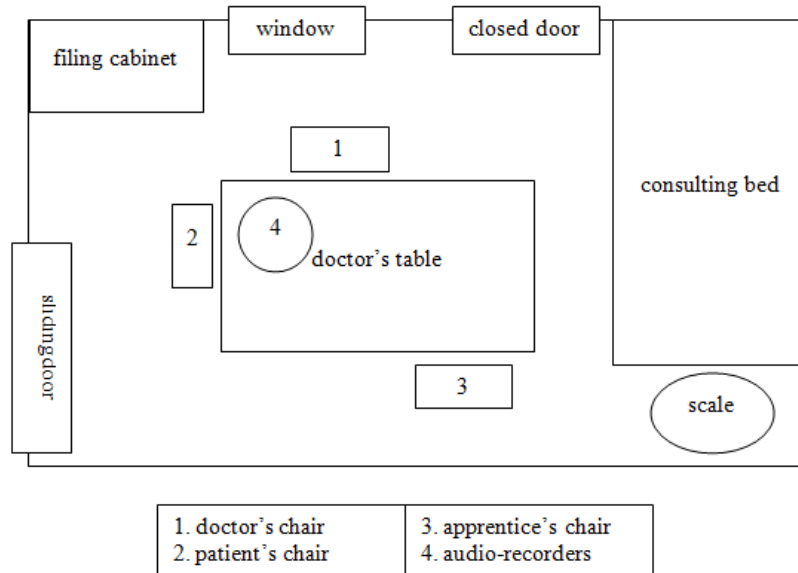
Figure 4.5. Male consulting room at Hospital B

Upon arriving at the hospital, patients take a number at the reception window, and then sit in a waiting area near the corridor. When their name is called, patients present their medical insurance (if any) and/or a referral letter to the receptionist prior to the consultation. They then go directly to the assigned consulting room for the medical consultation. As soon as the consultation is over, patients go to the reception area to complete the administrative formalities. After the consultation, inpatients or outpatients then move to a different ward to be re-examined by doctors there (see Figure 4.2).

Unlike the consulting rooms, the wards for inpatients at Hospital B are arranged in a different way to accommodate up to either four or six sickbeds per ward (see Figure 4.6). All wards have a front door and a backdoor, both of which are connected to the corridors that lead to other wards in the same block. Several wards have an ensuite toilet for seriously-ill, disabled, or elderly patients.

The consulting procedure for inpatients in the wards is a little different from that of the consulting rooms. Once patients obtain the referral paper from doctors at the Consultation Unit, they submit it with their medical record to a receptionist in a staff room nearby to be hospitalised as an inpatient. The receptionist then gives the referral paper and medical record to doctors in charge prior to the consultation. The receptionist allocates the ward subject to availability of the sickbeds and the seriousness of the patient's condition. It is then up to the ward doctor to collect this record from reception before the consultation. However, if the doctor is particularly busy, they may not have the opportunity to retrieve it in time. Once patients are settled in their sickbed, a nurse comes to take their blood pressure, and then ward doctors examine them for the first time. Each inpatient has a three-week period of hospitalisation under the treatment of one doctor, who is assigned to take charge of specific wards. Doctors visit their inpatients at least once a day to monitor their illnesses, but more visits are paid to cases that are more serious.
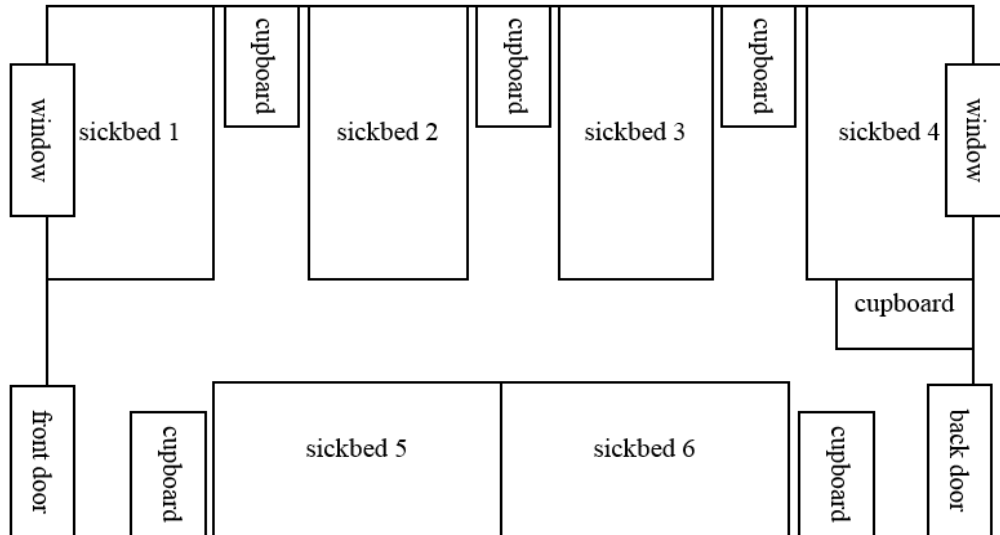
Figure 4.6. Typical inpatient ward
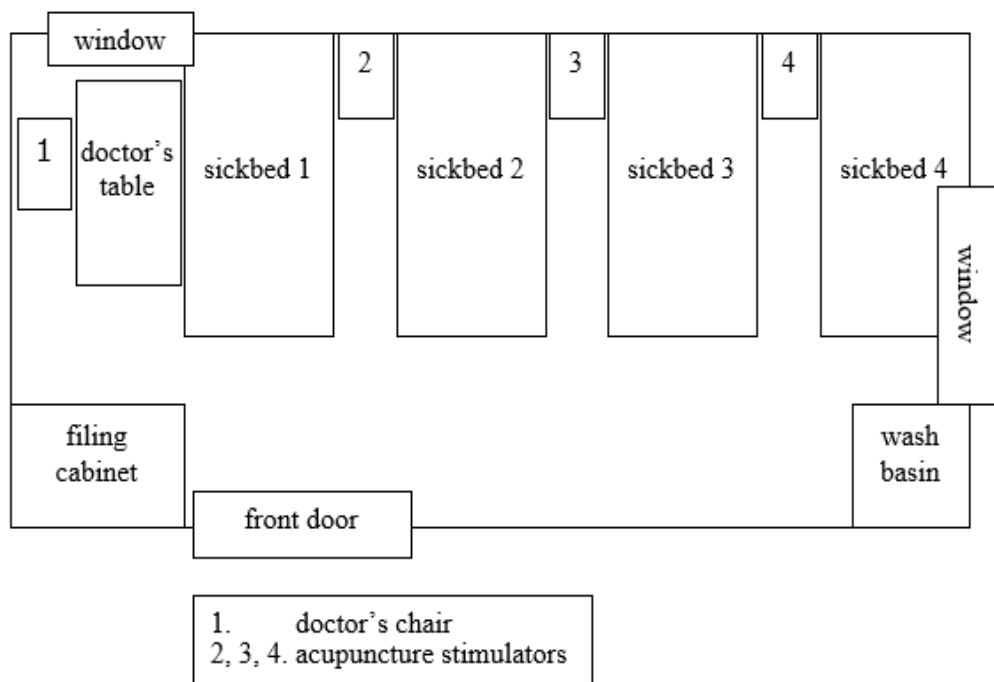
Figure 4.7. Typical outpatient ward

The wards for outpatients (see Figure 4.7) are different to those for inpatients. The consulting procedure for outpatients is as follows. First, they present the referral paper and medical record to a nurse in a staff room in the same block. The nurse then gives the referral paper and medical record to doctors in charge prior to the consultation. Next, patients wait their turn in the corridor. Then, they enter the

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assigned male or female ward, and lie on the sickbed. A nurse takes their blood pressure and then a doctor examines them. At the end of the consultation, patients may stay in the sickbed to receive therapies (e.g., acupuncture), which are often delivered by a nurse or an intern. Once patients have started the therapies, no more consultations are conducted. They return the next day to undergo the same treatment. Doctors do not often conduct an examination again.

The present study recorded all medical consultations in the consulting rooms (see Figures 4.3, 4.4, and 4.5), and the first medical interactions between doctors and patients in the wards (see Figures 4.6 and 4.7), regardless of whether they were the first or follow-up visits. During the recording sessions in the wards, two audio recorders were placed on the sickbeds next to patient heads, to gain maximum clarity of sound.

4.2 Participants

This study recruited 16 GPs and 93 of their adult consulting patients, inpatients, and outpatients who attended for first and follow-up visits. One doctor and one outpatient who were approached declined to participate (both at Hospital B). Twenty-six recordings were excluded due to the presence of a third person. Therefore, the remaining number of doctors and patients were 15 and 66 respectively. Hospital A had two doctors with 16 patients, and Hospital B had 13 doctors with 50 patients. In addition to participating in the recorded consultations, all of these participants completed demographic questionnaires (see Appendices A and B).

4.2.1 Doctors

Twelve doctors were male and three were female; all of the female doctors came from Hospital B. Six doctors were 26 to 40 years of age, four were 41-50, and five were above 50. On average, they had a mean duration of work experience of 16.2 years, with the longest of 29 years 5 months and the shortest 3 months. All of them received their medical training in Vietnam, and only one of them underwent overseas training in France in addition to his domestic training.

4.2.2 Patients

Twenty-six patients were male and 40 were female. The patients ranged in age from 20 up to 90 years old, and there were more elderly (60.5%) than young (39.5%)

patients. A large number of patients (N=38) had low levels of education (i.e., illiterate, mass education,[10] primary, and secondary) and 28 received high school education[11], vocational/technical training, or university education. One-third of the patients were white-collar workers (33.3%) while the other two-thirds were blue-collar workers (66.7%). The number of patients living in a city and in a town was the same (each had 26 patients), and 14 were from villages. There were 28 consulting patients, 12 outpatients, and 26 inpatients. The patient illnesses varied, from relatively new acute problems to continuing chronic conditions.

4.3 Types of medical consultation

Because it was not compulsory to make an appointment, the patient was allocated to a doctor who happened to be available. Their follow-up visits thus could be with the same doctor as in their previous visits, or with a doctor they had not seen before. In addition, patients sometimes neglected to bring their medical records with them to the consultation: if this happened, doctors would have no information to refer to beforehand. For this reason, there were three types of visits in the data: first visit, follow-up visit with the same doctor (henceforth, 'SDF'), and follow-up visit with a different doctor (henceforth, 'DDF'). Of the 66 visits, 35 were first visits, 9 were SDFs, and 22 were DDFs (see Appendix B). The 66 visits varied in length from 1.41 to 11.5 minutes (mean length: 5.9 minutes).

Despite their shared institutional objective of monitoring the development of the patient's health since the last visit (Cordella, 2001, 2004), the two types of follow-up visit were undertaken differently. While doctors and patients have already met at least once before to deal with the current concern in an SDF, they have never met to address this concern before in a DDF. Besides this, the SDFs in the consulting rooms differed from those in the wards. Doctors in the wards monitor the patient's health on a daily basis during a three-week period, but those in the consulting rooms only check the patient once. Their patients then either leave the hospital, or are hospitalised in the wards under the care of different doctors.

4.4 Ethical considerations

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[10] Mass education is a project launched in 1945 in order to reduce the rate of illiteracy for Vietnamese people.
[11] In the Vietnamese education system, primary school includes grades one to five, secondary school grades six to nine, and high school grades ten to twelve.

As no Vietnamese ethics committee exists to review research being done in Vietnam, the study was granted ethics approval by the University of Southern Queensland Research Ethics Committee (approval number: H16REA115). I provided the participants with a participant information sheet (see Appendices C, D, I, and J) and an informed consent form (see Appendices E, F, K, and L) before they entered the study. I informed them that their participation was voluntary, and that they may withdraw their participation at any time without penalty. Each recorded consultation and each questionnaire were given a specific number to ensure participant confidentiality. Participants were each assigned a code number, and all data collected were only identified by that code number. Pseudonyms have been used for all participants and any proper names to ensure confidentiality of participation.

4.5 Materials

Previous research in this area has highlighted the importance of audio or video recording, as either type is advantageous for understanding how doctors and patients interact (Garcez, Duarte, & Eisenberg, 2011; Mondada, 2012; Sacks et al., 1974). This study utilised audio recordings of consultations to obtain data on information-seeking practices used by doctors and the information disclosure practices used by patients.

4.5.1 Audio recordings of consultations

Conversation analysis involves examining the details of naturally-occurring social interaction, utilising video or audio recordings to capture these details. Naturally-occurring data imply that there is no interference or promptings from researchers during the course of recordings. Hence, these data are rich in authentic empirical detail (Ten Have, 2007). For this reason, role plays, experiments, or interviews (about opinions, attitudes, or scene descriptions that the researcher does not witness) are unacceptable. This is because these instruments tend to control the performance of the participants, thereby failing to ensure the authenticity of the interaction; moreover, the minutiae of behavioural variation may be lost (Goodwin & Heritage, 1990; Ten Have, 2007).

Given that hand-written notes or observations are vulnerable to memory failure and it is impossible to notice every detail of the conversation, the adoption of audio recording is critical as a faithful representation of the spoken word. Recordings of

naturally occurring interactions provide a more precise representation of the interactional events than such methods as field notes or on-site observations. The availability of the recorded data enables multiple observations, analysis, and re-analysis, which enhances the range and accuracy of the analytic observations. Via audio recording, researchers can listen to the tapes again and again to check and double check the data. Therefore, the information may be more reliable, valid (Bloor & Wood, 2006), authentic (Markle, West, & Rich, 2011) and rich (Liddicoat, 2007; Negrón, 2012). Last but not least, this availability also provides readers access to the evaluation of the research in such a way as to minimise any individual researcher idiosyncrasy or bias, and allows readers to judge for themselves the rigour of the analytic claims (Heritage & Atkinson, 1984).

Nonetheless, audio recording is not without concerns. In comparison with surveys, participants may feel reluctant to converse freely, as they know that their conversations are being recorded and may fear a breach of confidentiality (Bloor & Wood, 2006). The data collected may become biased as a result of this. Another disadvantage of audio recording is that it cannot capture salient non-verbal features like gaze direction and body gestures in face-to-face communication (Hutchby & Wooffitt, 1998; Williams, Herman, & Bontempo, 2013), which is the advantage of video recording.

However, audio recording has its own advantages. Research has found that live audio recordings can enhance doctor commitment to standardised performance of medical practice (Robinson, Tate, & Heritage, 2015) although this may not be a true reflection of actual practices. In addition, it is less likely to impede the interaction compared with video, as video requires the operation of a cumbersome camera which must be put in an exact location to capture the whole scene. Audio recorders are typically small, portable, unobtrusive devices that can be put in any place. Several studies (e.g., Dent, Brown, Dowsett, Tattersall, & Butow, 2005; Weingarten, Yaphe, Blumenthal, Oren, & Margalit, 2001; Williams et al., 2013) comparing the use of video recording and audio recording in clinical research concluded that the difference between videorecorded over audiorecorded data was negligible. More importantly, patients and doctors seem to be less likely to consent to being videotaped than audiotaped (Campbell, Sullivan, & Murray, 1995; Holst, 2010; Howe, 1997; Wynn, 1999).

As this study only focused on verbal exchanges, audio recordings were

considered sufficient as although body language is important, the verbal words remain central to diagnosis in medicine (Swartz, 2014). Further, as most of the previous studies in the domain of information-seeking have used audio-only recordings (e.g., Beckman & Frankel, 1984; Dyche & Swiderski, 2005; Holst, 2010; Marvel et al., 1999; Roter & Hall, 1987; Wissow et al., 1994), the present study is consistent with these studies.

As the material to be collected is subjected to a detailed transcription process, high-quality recordings are a requisite for capturing the subtlety of the interaction. Two high quality portable audio recorders were used to record each consultation in case one malfunctioned: a Zoom H2N Handy Audio Recorder with five built-in microphones and four different recording modes, and an Olympus WS-831 2GB Digital Voice Recorder with the low-noise directional stereo microphone. Both devices have intelligent noise cut technology and enhanced battery life, enabling them to record for more than 20 hours.

4.5.2 Demographic questionnaires

Both doctor and patient questionnaires encompassed items concerned with demographic information, so that further details could be added to the analysed recordings in response to the three research questions. Items in the doctor questionnaire included questions on gender, age, medical experience, and place of medical training (see Appendices G and H). Patient questions included gender, age, education, place of residence, occupation, and types of visit (i.e., first visit or follow-up visit; see Appendices M and N). Demographic results are reported in Appendices A and B.

Both questionnaires were piloted during the first week of the fieldwork, and some modifications regarding the content and questionnaire distribution were made during this phase. Particularly, question 3 in the original version of the doctor questionnaire (i.e., 'How long have you practiced medicine? ___month (s) ___ year (s)') turned out to be difficult to answer, as it involved counting exactly the total years and months of work experience. This question was thus modified as follows: 'When did you start working in medicine?', requiring the doctors to only respond in a day/month/year format.

4.6 Data collection procedure

Prior to recruiting doctors and patients, official permission was granted by the executive boards of the two hospitals. Once ethical and official permission was obtained, data collection commenced. The data collection procedure for the present study was composed of three phases: (i) getting to know the research site and research participants, (ii) recording the consultations, and (iii) administering questionnaires. The first phase served as the stepping stone for the rest.

In the first week of the fieldwork, I met with the administrators of the two hospitals to talk about the study. Gatekeeper support was gained by meeting the administrators in person to initiate the study and earn their trust for the study. Since the gatekeeper is an influential figure in such a hierarchical society as Vietnam (S. Đ. Nguyễn, 2012), this study would not have been possible without this support. During these meetings, I gained some information about the staff, the number of patients at the hospitals, and the difficulties that these hospitals were encountering. This information offered insights into the consultations to be recorded, and how best to approach the potential participants.

Having built rapport with the administrators, the consulting and general practice units were approached to discuss participation. Familiarisation with the research site and its residents is part of data collection (Barley & Bath, 2014; Schensul, Schensul, & LeCompte, 1999; Whiteley & Whiteley, 2006), and fundamental for understanding the situated activities to be recorded (Mondada, 2012). Schensul et al. (1999) listed four major activities that a researcher should do at this stage: (i) learning the language, rules of behaviour, norms, beliefs, social relationship, dietary patterns, and other aspects of life; (ii) locating and building relationships with the inhabitants; (iii) learning how to collect and record information unobtrusively and efficiently; and (iv) mapping the setting to sort out information.

Given this, I spent one week familiarising myself with the activities at the two hospitals to help plan the audio recording, carry out audio recording testing, and pilot questionnaires. To avoid any disturbance to doctors and patients, this was done close to noon, as patients often came in the early morning for consultations. During working hours, I stayed in the waiting areas, interacting with patients, nurses, or some doctors in order to understand the consulting procedure and patients' communication styles. This enabled me to gain insight into the number of first and

follow-up patients. I also observed the consulting procedure and the language use of participants so that I would be better able to adopt the proper communication style when interacting. Data during this session was collected in the form of field notes.

After this, I commenced recruiting medical doctors and their patients. At each hospital, one doctor introduced me to the participating doctors at their offices, consulting rooms, or wards. I then explained the study, and distributed participant information sheets and consent forms to those who were interested. I left them ample time to read the study description and ask any questions before consenting to participate. The research was described to the participants as a study of doctor-patient communication.

Following the doctors' acceptance to participate in the study, their patients were invited. On the dates selected by consenting doctors, patients were recruited. I was present in the waiting rooms to contact patients directly, to explain the study, and then distribute the participant information sheet and informed consent forms to the volunteers. Questionnaire and audio recording were undertaken on the date of contact in case patients (especially those in the consulting rooms) would not turn up on the following days.

A pilot session was conducted with voluntary participants during the first weeks of the fieldwork to obtain feedback on the method used (e.g., the location of the audio recorder). During the pilot study in the consulting rooms, I placed audio recorders on the doctor's table in a far corner to avoid any distraction to the participants. However, the sound was not clear enough as some patients spoke so softly. A participating doctor thus advised me to put them right in front of the speakers (see Figures 4.3, 4.4, 4.5). One more improvement during the pilot phase was related to the method used to pay the participants. Initially, before the consultation each patient was given VND 20,000 as a token of appreciation. A pilot doctor then suggested that gifts be given at the end of the consultation instead, as receiving gifts at the beginning made patients uneasy during the visits. From that point onwards, I put the recorders next to the patients' pillows (as patients often lay on the bed while consulting), and it was not until consultations were completed that gifts were presented to patients. Therefore, no change was made to the recorder location or the gift delivery in the wards.

Another modification concerned when to deliver questionnaires to patients: before or after consultations. Originally, the patient questionnaire was to be delivered

to all patients after consultations. However, the pilot study showed that patients in the consulting rooms were often busy with the administrative formalities after consultations, leaving little time to fill out the questionnaire. Therefore, this patient cohort completed the questionnaire prior to consultation. Patients in the wards completed it right after the recordings as they stayed in hospital for a longer time.

Each questionnaire took less than three minutes to complete, and was translated into Vietnamese before it was used. The doctor questionnaire was administered after their first consultation (as some doctors had more than one consultation recorded), when doctors were not busy. They filled it out in their offices and returned it on the spot. Patients in the consulting rooms completed their questionnaire while they were in the waiting areas, and those in the wards completed them at their sickbeds. For patients who were old or could not read or write well, I read the items aloud to them. They gave me the answers, and then I filled in the answers. Two illiterate patients signed by pressing their fingerprints on the consent forms. All patient questionnaires were returned to me on the day of distribution.

I adopted Cordella's (2004) approach to ensure the recordings were not intrusive. Prior to each consultation, I placed the audio recorders in a convenient place in either the consulting room or the ward, and retreated quickly before the consultation started. In this way, I was not present in the rooms at the time of audio recording. Each consultation involved only one doctor and one patient. Doctors operated the audio recorders. No participants asked for the recording to be stopped. From my observation, doctors in the consulting room started to fill out the patient's medical record as soon as the treatment recommendation has been agreed to by the patient (i.e., near the end of the consultation) while doctors in the ward did this after consultations were over: inpatient doctors did this in the staffroom and outpatient doctors returned to their table in the same ward to do this (see Figure 4.7).

4.7 Data transcription

Transcription lies at the core of doing CA, and serves as a resource for data analysis. Conversation analysis researchers tend to do their own transcription rather than delegate the whole task to a research assistant, because transcription allows researchers to become immersed in the data to enable the in-depth analysis that is required (Chatwin, 2004; Clayman & Gill, 2004; Markee, 2000). This is the most time-consuming research stage, as repeated listenings or re-viewings are needed to

uncover unnoticed aspects of the interactions so that they can be transcribed in meticulous detail, accuracy, and consistency.

This study employed ELAN software (EUDICO Linguistic Annotator) version 4.9.1 to assist in transcribing the recorded consultations verbatim. This software is able to measure pauses, silences, and overlaps in discourse. Although standard approach adopted for CA research measured silences manually (Hepburn & Bolden, 2012, 2017), mechanical measure could produce more accurate results. In my data, it was also able to separate doctor utterances from patient utterances automatically and effortlessly. Additionally, it allows for attaching annotations to the audio files, playing the annotated segments as many times as necessary, and studying the annotations for grammatical details or particular characteristics (Bickford, 2005). As the researcher, I repeatedly listened to the tapes and noted down the recurring features of the recorded communication in order to become familiar with the essential details of the recordings (Hutchby & Wooffitt, 1998).

Choosing notation symbols is of great significance for detailed transcriptions of interactions, as they can make visible the details of the talk (Psathas, 1990), especially for readers who do not have access to the original recording. It aims to render true sound and talk sequences into a written record by capturing the prosodic elements of what has been said (Heritage & Atkinson, 1984). The transcription system developed by Gail Jefferson is considered a standard representation of interaction, with an established history of use in CA (Liddicoat, 2007; Ten Have, 2007). It captures the speaker's prosodic behaviours, such as inhalation or exhalation, pauses, pitch, sound stretching, and tempo (Drew & Heritage, 2006b; Hepburn & Bolden, 2012).

The current study follows the techniques and symbols developed by Jefferson (2004b). Since the analysis of this study is based on audiotapes, only symbols related to verbal behaviours in Jefferson's system were used. In order to accommodate the Vietnamese data, two symbols (i.e., the hash sign and the plus sign) used in this study had different functions from the ones used in other CA studies (e.g., Hepburn & Bolden, 2017; Mondada, 2018). Particularly, the participants in this study often produced certain words so quickly that these words were almost inaudible. In such cases, the swallowed utterance or part thereof is enclosed within hashes (e.g., *Tôi #không# biết*) in the data extracts. The plus sign was used to join together two or more words in the Vietnamese transcription or the interlinear morpheme gloss (see

Transcription notation). As Vietnamese is a tonal language with diacritics, transcription here followed the International Phonetic Association convention, except for six tones which are illustrated with the vowel 'a': à (low-falling), ã (high-neutral-creaky-rise), ả (low-fall-neutral-rise), á (high-rising), ạ (low-fall-creaky), and a (high-neutral). The standard diacritics used for written language were employed but some were modified to properly represent the spoken language when necessary. To render the consultations faithfully, all audio files were transcribed in Vietnamese language first; however, only the segments used in this study (i.e., the information-gathering activities) were translated into English, as they were the major foci of this study.

4.8 Data analysis

This section describes the fundamental assumptions of CA and the steps in the analysis of the data in this study.

4.8.1 Fundamental assumptions of Conversation analysis

Conversation analysis has long been established as an approach to analysing medical discourse (Gill & Roberts, 2012; Heritage & Maynard, 2006a, 2006b; Maynard & Heritage, 2005). It focuses on the structure and actions of real-world medical consultations to unpack the sequential orderliness of discourse as an active social phenomenon (Sidnell, 2010), thus highlighting how interactants jointly construct reality to reach their goals. As the general development and basic assumptions of CA have already been mentioned in Section 2.4, in what follows I present the basic types of interactional organisation that are fundamental to CA.

In CA, talk-in-interaction is analysed in relation to action formation. Action formation arises from the notion that talk is a sequence of actions, and different actions are performed and embedded in sequences. Actions refer to the notion that we do things with our discourse. According to Schegloff (2007), action formation involves the speaker's enlistment of various resources (e.g., linguistic formulation, context, or non-verbal cues) as a preparation for building a specific action. For example, action formation contributes to the recognition that an utterance is to be heard as an assertion, an invitation, or a request for information (Heritage, 2012).

Action formation is accomplished through different levels of interactional organisation, such as turn-taking, sequence organisation, repair organisation, and the

organisation of turn design (Ten Have, 2007). Lying at the core of conversations are turns and turn-taking. Sacks et al. (1974) developed a turn-taking system as a basic form of organisation for conversational interaction. The turn-taking system describes how exactly turn-taking happens without a pre-allocation of turns, but locally, at each transition relevance place (TRP; i.e., the place where a current speaker can or should exit so that another speaker can join the talk). A turn can be defined as "one interactant's continuous period of talk" (Wynn, 1999, p. 35), varying widely in length and ordering, including a gesture, a sound, a single unit, or a long complete sentence. Turn-taking is orderly and locally managed, with the transition from one speaker to the next marked by few gaps, a minimum of silence, or little overlapping speech without overly-long pauses (Clayman, 2012; Irish & Hall, 1995). This set of turn-taking rules governs interactants' organisation of talk for the maintenance of orderliness within interactional conversations.

Pivotal to CA is the notion that conversations are sequentially organised, one turn following another turn (e.g., question–answer, invitation–acceptance/declination, or greeting–greeting). This sequence is organised elementarily under the rubric of adjacency pairs (Schegloff & Sacks, 1973), that is, the units of sequence construction that organise most courses of action in conversation. Adjacency pairs compose of two turns that are often adjacent to each other and follow a conditional relevance that

given the first [utterance], the second is expectable; upon its occurrence it can be seen to be a second item to the first; upon its nonoccurrence it can be seen to be officially absent – all this provided by the occurrence of the first item (Schegloff, 1968, p. 1083).

Schegloff and Sacks (1973) point out that adjacency pairs characteristically are (i) composed of two turns, (ii) generated by different participants, (iii) adjacently positioned (iv) relatively ordered (i.e., first-pair parts precede second-pair parts), and (v) pair-type connected (e.g., greeting – greeting or question – answer). By way of illustration, there are two parts in a question-answer sequence, each uttered by a different speaker. The first-pair part action (i.e., question) adjacently precedes the second-pair part action (i.e., answer). Once a question is projected with some form of

addressing, it exerts a normative constraint on the type of action to which the recipient should respond (Drew & Heritage, 2006b; Raymond, 2003).

Along with the turn-taking rules and sequence organisation, Schegloff, Jefferson, and Sacks (1977) also introduce a system of repair (or correction) to manage the dimensions of conversational interaction, construct shared understanding, and maintain or restore intersubjectivity. The appearance of repair arises from the idea that actions operating in conversations are vulnerable to errors, troubles, and violations. Repair refers to the practice whereby one interactant suspends the ongoing course of action to resolve their problem in hearing, speaking, or understanding the talk. There are four types of repair: self-initiated repair (i.e. repair initiated by the speaker of the trouble source), other-initiated repair (i.e., repair initiated by any party other than the speaker of the trouble source), self-repair, and other-repair. Trouble source is the target of the repair initiation to refer to an ostensible problem in speaking, hearing, or understanding. Self-initiated repair interrupts the progressivity of the turn, and other-initiated repair interrupts the progressivity of the sequence (Kitzinger, 2012). Having said this, they are related to each other, and this relatedness is organised (Schegloff et al., 1977).

Central to turn-taking is the notion that turns are made up of a succession of turn-constructional units (TCUs), like single words, clauses, sentences, and phrases. TCUs are context-sensitive, and use prosodic, pragmatic, non-vocal, or syntactic cues to mark their completion (Clayman, 2012). The possible completion point of a TCU constitutes a transition relevance place where the transfer of speakership is coordinated. Speakers can deploy both verbal and nonverbal resources, including lexical choice, syntax, and gestures, in designing their turns.

In addition, turn construction is shaped by the fundamental principle of recipient design (Sacks et al., 1974). Recipient design is taken from the position that speakers express their sense of relevant context (i.e., knowledge shared by all speakers involved) through the way they design their talk. It means to whom the turns are addressed and how speakers design or construct their talk in order to display their orientation and sensitivity to recipients. One basic facet of recipient design is that speakers presume what recipients already know, how well they know it, and what is new to them (Sidnell, 2012b). This means speakers should not tell their recipients what they already know (Terasaki, 2004). This is manifested in the speaker's selection of words, topics, sequence orderings, or options. This recipient-

design principle is a resource for speakers to design talk and for recipients to interpret talk, as the latter need to track the trajectory of a turn to see if it is designed for them (Liddicoat, 2007).

4.8.2 Steps in the analysis

Once transcribed, the recordings were analysed. Conversation analysis favours unmotivated examination (Hoey & Kendrick, 2018; Sacks, 1984), an approach to the analysis of interaction in which the researcher does not have any assumption about the pattern of talk. Following Sidnell (2012a), the basic analytical method of CA is characterised by the back-and-forth movement between a particular phenomenon, and a more synoptic view of the collection out of which the phenomenon is identified. A collection often consists of, at a minimum, two instances of a phenomenon. In this study, analysis was generated through four steps: (i) making observations, (ii) identifying and collecting discourse phenomena, (iii) developing the analysis, and (iv) translating the data into English.

4.8.2.1 Making observations

Observation refers to listening to or viewing the recordings in conjunction with looking at the transcripts. Observation, according to Sacks (1984), is a basis for theorising in CA. It is a key to identifying recurrent and stable details of verbal and non-verbal talk (e.g., gesture, gaze, or body posture). By observing the data, the researcher can discover the recurrent structures (Sidnell, 2010). This is why observation was an indispensable step in the data analysis of the present study. I focused my observation only on the information-seeking activities during medical consultations to match the foci of my study. As the reasons why a patient comes to the doctor's office may shape the consultation structure, I located the doctor's information-gathering and the patient's disclosure by looking at the whole consultation, with reference to the structural framework developed by Byrne and Long (1976). This framework was adopted as it can accommodate both first and follow-up visits (see Section 3.2).

4.8.2.2 Identifying and collecting discourse phenomena

This step requires the researcher to be immersed in the data to identify the systematicity and recurrence of a practice (or phenomenon) for collection. However,

this practice of identification and collection is not a straightforward one, partly due to the various ways of dealing with the phenomenon. From the guided observations in the first step, I started to collect the cases according to two themes: doctors' information-seeking practices and patients' information disclosure practices. I collected the practices deployed during the problem presentation, history-taking and physical examination, and treatment and post-consultation. There were some deviant cases which did not appear to conform to the proposed pattern. Therefore, deviant case analysis suggested by Maynard and Clayman (2003) was then used to check the validity and generality of a proposed phenomenon. Specifically, a separate analysis of the deviant cases was carried out to see how these cases differed from the proposed ones.

4.8.2.3 Developing the analysis

Developing the analysis involves analysing both the generic feature of that practice, and its generic function, in association with the details of some specific contexts. I adopted the approach proposed by Pomerantz and Fehr (2011) to guide my analysis. Doctor information-seeking practices were taken as a point of departure, from which I looked at patient disclosure. First, I identified the common types of action performed by doctors in different stages of the consultations. Then, I put all information-seeking actions into a separate file to differentiate them based on elicitation strategies (e.g., questions, repeats, or fishing). Next, I concentrated on the sequence to examine its opening and closing. Finally, I selected a turn in that sequence for detailed analysis. For example, I looked at the first-pair-part turn initiated by doctors, or alternatively, by following next-turn proof procedure (Sidnell, 2012a), I looked at the second-pair-part turn disclosed by patients in response to a doctor's elicitation in order to analyse the doctor's turn. The next-turn proof procedure means that by examining a patient's response, I could see how patients understood the doctor's elicitation in the prior turn, thus I was able to base my analysis of the doctor's elicitation on this understanding. Analysis was then done by examining turn-taking, sequence organisation, repair, and turn design to unpack the interaction (Ten Have, 2007). This practice aims to understand the deployment of doctor elicitation strategies in discourse. Similar procedures were also applied to patient disclosure of information.

4.8.2.4 Translating the data into English

The raw data of this study were in Vietnamese, requiring translation into English for readers who are unable to understand Vietnamese. Data were analysed in the original language, then the segments presented in this study were translated into English. Addressing the importance of translation in transcription, Liddicoat (2007) argues that translation should not distort the original conversation. Given the essentiality of granting readers access to the data in its original form, I present both the original and the translation in the analytic chapters. Following the guideline of transcribing talk in languages other than English set out by Hepburn and Bolden (2012), I provide a three-line transcription. Specifically, I display the Vietnamese data accompanied by a morpheme-by-morpheme interlinear gloss plus a translation in each utterance. Due to the mismatch in some basic structures between Vietnamese and English (see Section 2.3.1; Haussamen, Benjamin, Kolln, & Wheeler, 2003; H. Đ. Nguyễn, 2009), sometimes Vietnamese speakers express information in contexts in which English speakers would not, and vice versa. Thus, my priority in the translations was to strike a balance between the naturalness of the English, and faithfulness to the original language. For the sake of clarity, I also occasionally included some information that was not clear in the Vietnamese language.

Some differences between Vietnamese and English were noted clearly in the translation process. Firstly, as mentioned previously, responses to negative polar questions in Vietnamese were opposite to those in English. Hence, when interpreting these cases, readers are recommended to look at the translation for exact meaning. Secondly, some notes about the language choices (e.g., *ngoại khoa* 'surgery' was translated as 'non-surgical problems'), word order (e.g., noun preceding adjective in a noun phrase), or cultural features, were also added to the texts on a case-by-case basis. Thirdly, the participants in this study mostly come from the central regions, and so speak central-region dialects. Despite few significant differences among the dialects of the three regions, some of the participants' dialectal features were difficult for those speakers from the other two regions to understand (e.g., 'swell' is *sưng* in standard Vietnamese, but *cảy* in the central-region dialect). In the transcripts, these words were made explicit through translation. The last point is that due to the syntactic differences between Vietnamese and English, the hesitation markers or pause-fillers (e.g., *ờ* 'uh'), pauses, and stuttering talk are not included in the free translation. Readers are suggested to refer to the gloss for such features.

4.9 Chapter conclusion

This study uses CA to investigate information-seeking activities in doctor-patient interactions in public hospitals in Vietnam. Chapter 4 has sketched out the methodology used in this study to answer the three research questions. We now move to analytic observations and discussion.

Chapter 5

Problem presentation

5.0 Introduction

The doctors and patients in this study sought and disclosed information throughout the whole consultation, not only during history-taking or the physical/verbal examination. I have separated the problem presentation from the other stages, as this is the only stage when patients are institutionally licensed to describe their concerns in their own terms according to their plans (Heritage & Robinson, 2006a, 2006b; Robinson & Heritage, 2005, 2006; Stivers, 2002b). This chapter focuses on problem presentation in order to gain analytic insight into the doctors' design of information-seeking acts, and to look closely into patients' strategies for disclosing their main concern.

Chapter 5 consists of two main sections: doctor elicitation (Section 5.1) and patient disclosure of concerns (Section 5.2). It should be noted that in the analytical chapters 5, 6, and 7, I do not discuss all 66 visits. Instead, I have selected for presentation and discussion the ones that represent clear examples, and are most representative, of the phenomena being discussed.

5.1 Doctor elicitation

As stated previously, the medical consultations collected in this study included first visits, same doctor follow-up visits (SDFs), and different doctor follow-up visits (DDFs). Given that these two visit types differ from each other in terms of the doctor's medical responsibilities, the doctor's knowledge of the patient may also differ as a result. In turn, this difference in knowledge may affect how the doctor formulates their information elicitors. Thus, it seems best to look at each visit type separately.

5.1.1 First visits

As a rule, eliciting new concerns occurs in the first visit, when the doctor meets a new patient. This practice will be demonstrated below.

5.1.1.1 Consulting room

The design of doctor elicitation in first visits to the consulting room works to display the doctor's lack of prior knowledge of the patient's presenting problem(s). This is expressed through a wh-question format positioned in the first-pair part of the problem presentation sequence: 'What's the problem?', 'What brings you to hospital/here + [name of patient]?', 'What seems to be the trouble + [name of patient]?', or 'Where does it hurt + [name of patient]?'. This question format embodies presuppositions about the existence of a certain problem(s) that prompted the patient's visit; thus, in employing this format, the doctor aligns with the principle of problem attentiveness (Stivers, 2007).

Extract 5.1 presents a typical example of how a wh-question format is used by a doctor to elicit the patient's major concern in the first visit to the consulting room. This extract is between doctor Hoang[12] and patient Mi, who has presented at the hospital because she has been suffering from depression (line 3). In this consultation, Hoang uses two wh-questions called general inquiry questions (Heritage & Robinson, 2006b) to elicit Mi's major concern (line 1). This extract takes place right after Hoang has taken Mi's blood pressure.

```
Ex. 5.1: B 2 & 20

1 D:→    rồi: (.) con      khai bệnh    #đi#=con      Ⱡđau::   răng?
  Hoang  OK       offspring tell problem PRT  offspring trouble what

         'OK. Tell me what the problem is. What seems to be the trouble?'

2 P:     u:::m  (0.9)  dạ (.) con       bữa+ni =con        hay
  Mi     mmm           HON    offspring lately offspring  usually

3        người hay    suy+nhược  a
         body  usually depress   PRT

         'Mmm. I've been suffering from depression lately'

4        (0.2)

5 P:     lại là  con       sợ    °co:::n° (1.0)ờ:: (0.2)
  Mi     and COP offspring worry offspring      uh

6        về   (.) Ⱡtự+nhiên      cái  mặt  con
         about    for+some+reason CLA  face offspring

7        tự+nhiên        nổi-    (.) mụ- mụn  (cứng) luôn,
         for+some+reason break+out    pimple lots  PRT

         'and I'm worried because, for some reason, my face's broken out in
         pimples'
```

Right at the outset of the consultation, doctor Hoang uses the *appositional*

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[12] All names have been replaced by pseudonyms.

beginning (Sacks et al., 1974) *rồi:* ('OK'; line 1) as a turn-entry device in order to project the beginning of a new activity (Beach, 1993). An appositional beginning (e.g., 'well', 'but', 'and', 'so') is used to begin a turn without revealing much about the constructional features of the turn thus begun (Sacks et al., 1974). This *rồi:* ('OK') can also be treated as a *sequence-closing third*[13] (Schegloff, 2007) which, in this case, closes off the previous sequence that was concerned with Mi's blood pressure. Thus, *rồi:* ('OK'), as both a sequence closing-third and an appositional beginning, sets up the problem presentation stage. The word *rồi:* ('OK') is elongated and followed by a pause, indicating that a turn change is underway. Hoang then poses two general inquiry questions consecutively to initiate the problem presentation (line 1). The first one, *con khai bệnh đi* ('tell me what the problem is'), is a grammatically complete TCU (Sacks et al., 1974), but Hoang extends this turn with a second TCU, *con đau răng?* ('what seems to be the trouble?'). According to Heritage and Robinson (2006b), these general-inquiry elicitors address Mi's problem directly, formulate Hoang's agnostic stance (through the words *khai* 'tell' and *răng* 'what') vis-à-vis the precise nature of Mi's medical condition, and license Mi's presentation in her own words. Therefore, they invite Mi to present her concern immediately. Although both questions display Hoang's presupposition that Mi has a concern (i.e., *bệnh* 'problem', *đau* 'trouble'), they invite Mi to describe the problem anew, thus positioning Hoang as a relatively unknown hearer (Heritage & Robinson, 2006b).

With respect to the content, doctor Hoang's two general inquiry questions (line 1) with final-rising intonation – a feature of Vietnamese interrogation (Luu, 2010) – aim to elicit patient Mi's major concern. The first question, *con khai bệnh đi* ('tell me what the problem is'), seems more general than the second, *con đau răng?* ('what seems to be the trouble?'), regarding the content it is intended to elicit, as it allows Mi to voice multiple concerns she may be experiencing. The word *khai* ('tell'; line 1) requests Mi to disclose all concerns, regardless of whether they are minor or major, physical or psychological. The second general question using the words *đau* ('trouble'; line 1) and *răng* ('what'; line 1), by contrast, exclusively indexes the symptoms (see Section 6.2). It triggers Mi's description of the problem and calls for the identification of one specific physical ailment.

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[13] A sequence-closing third turn, such as 'oh', 'I see', or 'okay', closes off the question-answer sequence.

Interactionally speaking, doctor Hoang's chaining of two questions at line 1 violates the rules for turn-taking (Sacks et al., 1974). Although he has selected patient Mi (glossed as *con* 'offspring', but ellipsed in the translation) as the next speaker in his first TCU, *con khai bệnh đi* ('tell me what the problem is'), he does not stop speaking at the TRP, *#đi#*. Rather, he *rushes through* (Schegloff, 1982; symbolised by '=') this TRP with clipped sound at the particle *#đi#* (line 1) to voice the second question, without allowing any opportunity for Mi's response. Rush-through is a practice in which speakers keep the floor past a turn's possible completion by speeding up the pace of the talk (Schegloff, 1982). However, both questions have a similar focus on Mi's health (expressed by the lexical items *bệnh* 'problem' and *đau* 'trouble'), which suggests that Hoang is trying to make his previous question more specific for better understanding. In response, Mi presents her lay diagnosis of the illness (Pomerantz, 2002), *suy nhược* ('depression'; line 3) in the format of a fact without any uncertainty marker. These two features show that Mi is treating her diagnosis as fully endorsed (Pomerantz, 2002). After a micro pause of 0.2 seconds (line 4), Mi expands her turn to disclose her symptoms (lines 5-7), and making a specific reference to *mụn* ('pimples'; line 7). This general-to-specific description indicates that she is trying to describe the symptoms of her depression in response to Hoang's second question. Her response to Hoang's second question is consistent with what Sacks (1987) has identified as *preference for contiguity*; that is, any first answer is an answer to the nearer question (i.e., the second question in this instance).

Extract 5.1 has illustrated how doctors design their wh-formats to initiate the problem presentation in the first visit to the consulting room. As described in Section 4.1.3, the consulting room is the first contact point for a new patient who has come to hospital for medical assistance. The talk in a first visit is inevitably shaped by the fact that this is the first time the doctor and the patient have met to deal with the patient's health concern. Therefore, it is institutionally and epistemically relevant for doctor elicitation to use a wh-question format, as this conveys their lack of knowledge of the patient's problem. By means of this wh-question format, the doctor is able to focus directly on the problem, and encourage the patient to provide an in-their-own-words description of their problem. In turn, this description may have some bearing on the diagnosis and treatment recommendation.

5.1.1.2 Ward

Doctors in the ward adopt the same wh-question formats as those in the consulting room, but some of these formats convey the doctor's pre-existing knowledge of the patient's problem. For example, 'Where does it hurt the most?', 'How long have you had this/these problem(s)?', or 'How is/are + [name of problem(s)]?'. The selection of such words as 'the most' or 'this/these', or naming the problem(s), carries an implication that the doctor has basically grasped the patient's problem but may not be sure of the severity, or the medical history, of that problem. Given this implication, some of these questions are also considered *history-taking questions* (Heritage & Robinson, 2006b), which bypass the problem presentation and set up a constrained agenda for the patient's responses.

In Extract 5.2, I exemplify how the doctor designs a history-taking question in order to initiate the patient's problem presentation in a first visit to the ward. Patient Nhu has been referred from a doctor in the consulting room, where she has just undergone a general examination. In this extract, doctor Si chains together two history-taking questions in order to elicit the symptoms of Nhu's main concern: pain in her kneecaps (lines 1 and 3).

```
Ex. 5.2: B 8 & 52
1 D:→    HAI #cái# khóp+gối ch:::- (.) đau  răng?
  Si     two CLA   kneecap              pain how

         'How are your kneecaps?'

2        (.)

3 D:     nhúc    ↑trong a?
  Si     irritate inside INT

         'Irritated inside?'

4        (1.1)

5 P:     bị- bị- bị  có- (.) có      DỊCH  nũa,
  Nhu            get         produce fluid as+well

         'And they've been producing fluid as well'

6        (0.3)

7 D:     à::
  Si     oh

         'Oh'

8 P:     <em              coai nơi cái phi:m với cái>
  Nhu    younger+brother  look PRT CLA x-ray  and CLA

9        siêu+âm      a  tề
         ultrasound  PRT PRT
```

```
            'Please¹⁴ have a look at the X-ray and the ultrasound result'

10 D:      °rồi°
   Si      OK
            'OK'
```

Doctor Si skips the greeting stage of the consultation and starts with two questions about Nhu's kneecaps (lines 1 and 3). The first question (line 1), with the interrogative marker *răng* ('how'), marks itself as a general inquiry. However, in this question, Si locates the pain area (i.e., kneecaps), which communicates that he has already grasped Nhu's main concern, and so this is a history-taking question instead. After a micro pause (line 2), Si projects the second question, *nhức* ↑*trong a?* ('irritated inside?'; line 3). This is syntactically a declarative, but is produced with an upward-intoned ending – an indicator of Vietnamese question-formation (Luu, 2010; see Section 2.3.4). The declarative component formulates 'B-events' information to which Nhu has primary access (Labov & Fanshel, 1977). According to Labov and Fanshel, B-events in interaction mean the knowledge to be sought is known to the addressee (i.e., Nhu) but not the addresser (i.e., Si). This second question, stressing *nhức* ('irritated'; symbolised by underlining), looks for Nhu's confirmation of her symptom (Heritage & Robinson, 2006b), which suggests that this question is also a history-taking question.

Similar to doctor Hoang in Extract 5.1, doctor Si's chaining of a pair of questions in lines 1 and 3 violates the rules for turn taking. The first question (line 1) is general while the second (line 3) is more specific. The two questions are separated by a very short pause (line 2), without an opportunity for patient Nhu to respond. They both address Nhu's concern, but the second one, *nhức* ↑*trong a?* ('irritated inside?'; line 3), seems to look for a confirmation of the information that is available in Nhu's medical record. Declarative questions are strongly polarised in both positive and negative directions; thus, the second question with the leading word *nhức* ('irritated'; line 3) is polarised in a positive direction to invite a *preferred next action* (Pomerantz, 1984a). In this case, it is a 'yes' response. This question thus indexes a strong commitment to the likelihood that Nhu's kneecaps are irritated (Heritage & Clayman, 2010), and embodies Si's prior knowledge of Nhu's concern.

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¹⁴ To express politeness in imperatives, apart from using *xin vui lòng* ('please'), Vietnamese speakers preface their utterance with an address term instead of a zero-sign-address imperative. Therefore, 'please' in the free translation comes from the address term *em* ('younger brother' in the gloss).

Like patient Mi in Extract 5.1, patient Nhu's response demonstrates that she is addressing the second question. After a delay of 1.1 seconds (line 4), Nhu gives a response which can be considered *nonconforming* (Raymond, 2003) to the second question because it contains neither a 'yes' nor a 'no'. However, given the 'and' in line 5, it speculatively suggests that there is some sort of confirmation given; that is, Nhu may have given a nod in response during a delay of 1.1 seconds (line 4). Her response in line 5 appends another piece of problem-indicative information (Nishizaka, 2011) to the second (line 3) rather than the first question (line 1). In particular, the word *nữa* ('as well'; line 5) means that something has been added to the previous opinion, that is, Si's word *nhức* ('irritated'; line 3). Via her response, Nhu continues the sequence of assessment initiated by Si's second question. Si receipts Nhu's presentation with a *marked confirmation* (Lee, 2012; Stivers, 2011) in the form of an *à*-preface (line 7), in order to propose a change in his locally current state of information (Heritage, 1984a, 2018a). Marked confirmations (e.g., 'absolutely', 'certainly') are affirmative lexical items used in response to closed questions, but they are not varieties of 'yes' or 'no'. As *à::* ('oh'; line 7) is produced in a stretched-out fashion, it indicates that Si has just been informed of Nhu's information, and thus registers that Nhu's symptom is new.

As this is a referral consultation from another health professional, doctor Si's questions (lines 1 and 3) are shaped by the preceding interaction (Heritage & Robinson, 2006b), which, in this case, is the patient's consultation with another doctor in the consulting room (see Section 4.1.3). Both questions embody his claims to have had some prior knowledge of Nhu's concern (i.e., pain in her kneecaps) from the referral letter, which establishes mutual understanding of the patient and achieves alignment not only between the patient and the attending doctor, but also between these two participants and the referring doctor (White, 2011). This question design conforms to the conversational norm of not saying things that are already known (Terasaki, 2004). However, it seems that Si does not grasp the level of severity of the pain and thus seeks confirmation of this in the second question (line 3). Through this question, Si also obtains further information (i.e., there is fluid in the kneecaps). Overall, Si seems to bypass the problem presentation stage by setting a context for Nhu's response to revolve exclusively around the problem with her kneecaps. His two questions thus constrain Nhu's answers and do not reflect question design based on the type of visit. At the same time, Si's approach in this case is characteristic of

first visits to the ward, where patients often have a medical record that describes their problem. In other words, Si frames these questions as if he has seen Nhu before and this is an SDF.

In sum, in spite of the fact that doctors in both consulting rooms and wards have a shared purpose of indexing new concerns for first visits, each doctor employs various questioning strategies to elicit the patient's presenting concerns. They employ wh-question elicitors, but these elicitors differ somewhat in their turn design and word selection. These differences reflect variation in the doctor's epistemic stance towards the patient's problem. In particular, doctors in the consulting room display their lack of knowledge concerning the patient's problem by using general inquiry questions which aim to obtain information about the problem and its symptoms, and which also encourage patients to present the problem in their own terms. Doctors in the ward tend to claim some access to the patient's problem by using history-taking questions that call for the patient's (dis)confirmation of concrete symptoms. This difference may arise from the institutional setting of the Vietnamese hospital, where an inpatient/outpatient has to be given a consultation in the consulting room prior to being sent to the ward for another consultation. The referral letter from doctors in the consulting room contributes to the epistemics of the doctors in the ward, and may reflect differences in their elicitation design.

Having presented the first visits, Chapter 5 now moves to the follow-up visits. I will deal with the SDFs in the consulting room first, followed by the SDFs in the ward, and end with the DDFs at both locations.

5.1.2 Same doctor follow-up visits

In the present context, seeking follow-up concerns often occurs in SDFs. Robinson (2006) argues that doctors' methods of eliciting follow-up concerns aim to (i) demonstrate their own knowledge of a specific concern; (ii) look for an evaluation of, or an update on, a specific concern; and (iii) embody their claim to have had pre-existing knowledge of the concern in question. For this reason, doctors would not ask patients to present their concerns in full all over again (Gafaranga & Britten, 2007). Rather, they ask patients to assess their own health recovery or raise any new concerns. However, the doctors in the consulting room of this study do not always follow that pattern. Although they know that patients are coming for a follow-up

visit, their elicitation communicates their lack of knowledge of the patient's existing concern.

5.1.2.1 Consulting room

Doctors in SDFs to the consulting room employ either wh-questions or polar questions to elicit the patient's problem presentation: (i) 'You have / are suffering from + [name of problem]?', (ii) 'Where does it hurt?', or (iv) 'What brings you to hospital/here?'. In epistemic terms, the first format communicates that doctors already have access to the patient's problem and they are looking for confirmation of this. The second format embodies the presupposition that the patient has a biomedical problem but it is still unknown to doctors. The third format claims the doctor's lack of knowledge of the patient's presenting problem, and thus elicits biomedical and/or psychosocial problems. Although all these formats are used in SDFs, each displays the different epistemic stances that doctors have on the information targeted by the questions.

Extract 5.3 illustrated the first format. This is an interaction between doctor Nam and patient Huong, who has had a herniated disc in her spine for a long period. Huong has received treatment at this hospital and has been examined by Nam once previously. In this extract, Nam uses a declarative question (lines 1-2) to elicit Huong's presentation of her problem.

```
Ex. 5.3: A 1 & 9
1  D:     rồ:i (.) đợt    ni   chị          vô         cũng
 Nam      so       period this older+sister hospitalise also

2         đau    lại   vù:::::ng (0.6) cũ  nó   ha:?
          Problem again part            same that INT

          'So, you're seeking treatment for the same problem again?'

3         (0.5)

4  P:     dạ:::
Huong     yes

          'Yes'

5         (0.2)

6  D:     vùng lưng đây  hí:?
 Nam      part back this PRT

          'It's in this part of your back?'

7  P:     #hắn# có  ĐAU (.) có  giảm (0.2) #như rứa# bác   nã¿
Huong     it   PST pain    PST better     like that doctor PRT

          'The pain's somewhat better, doctor'
```

```
8        (0.2)
9  D:    dạ  rồ:::i
  Nam    HON OK
         'OK'
```

The visit opens with doctor Nam's *gloss-for-confirmation question* (Heritage & Robinson, 2006b; lines 1-2) that looks for a confirmation of Huong's current problem. A gloss-for-confirmation question looks for confirmation of a generalised gloss of the patient's concerns (Heritage & Robinson, 2006b). This question makes Huong's response an immediately relevant next action (Raymond, 2003). Its design reflects Nam's possible difficulty in identifying the health concern of a patient that he has seen sometime before but may not fully remember. For instance, notice that his opening question[15] is delivered with a long sound-stretch on the word *vù:::::ng* ('part' in the gloss; line 2) and a 0.6-second pause (line 2) in the mid-turn. Moreover, he uses the general-but-safe word, *cũ* ('same'; line 2), plus the *recognitional demonstrative of reference* (Enfield, 2012; Himmelmann, 1996), *nớ* ('that' in the gloss; line 2), referring to the locally visible patient's body (Hindmarsh & Heath, 2000), to initiate the problem presentation. This question design turns out to be a good solution as it receives a conforming answer, *dạ:::* ('yes'; line 4), from Huong. It is then at this point that Nam launches another declarative question that substitutes the location of the ailment, *lưng* ('back'; line 6), for the non-specific word *cũ* ('same'; line 2). In response, Huong does not answer Nam's question overtly (i.e., 'yes') but volunteers a general assessment by using a pronoun *#hắn#* ('it'; line 7) to anaphorically refer to the word *lưng* ('back'; line 6) in Nam's turn. In giving this assessment, Huong registers this visit as a follow-up.

In this consultation, doctor Nam's information-seeking acts exhibit his prior knowledge of Huong's recurrent concern, albeit apparently a vaguely remembered concern. Syntactically, each of his two questions (lines 1-2 and 6) is designed in the form of a declarative with a B-event. This strategy favours a 'yes' response (Boyd & Heritage, 2006) – an indicator of strong certainty. Furthermore, such lexical items as *lại* ('again'), *cũ* ('same'), and *nớ* ('that' in the gloss) indicate that Nam has dealt with this concern before. We know that Nam has not read Huong's medical record as, later in the consultation, Huong tells Nam that she has left her medical record at

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[15] In this study, 'opening questions' refer to the questions used to seek the patient's major concern (e.g., 'What brings you to hospital?').

home (data not shown). Hence, this is an SDF. Nevertheless, Nam does not elicit Huong's assessment of her recovery – a basic step in a follow-up visit (Cordella, 2004) – to see if the previous treatment method has worked or not. It can be inferred from this that Nam has neither attended, nor given any treatment, to Huong during her previous hospitalisation. Rather, he most likely performed a brief examination on her last visit, and then referred Huong to another doctor in the wards, as is consistent with consultation procedures in the wards.

While doctor Nam's information-seeking approach is characteristic of an SDF in the consulting room, this is not the case in Extract 5.4, in which doctor Quynh's elicitation is more appropriate for a first visit (lines 3-4). In this extract, Quynh designs her turn following the third format, 'What brings you to hospital/here?', to present herself as an unknown hearer. Trang is a consulting patient who came to this hospital six months ago for her chronic arthritis. On that occasion, she bought some traditional medication to take at home. Now she has come again for a follow-up check to obtain more of this medication.

```
Ex. 5.4: B 1 & 5

1   D:     O    Ma:i Thu Trang  hi?
Quynh      aunt Mai  Thu Trang  INT

           'You're Mai Thu Trang?'

2          (0.4)

3   D:     O     ↑Trang,  (0.2) rúa O    đau     ↑chi:  mà  O
Quynh      aunt  Trang          PRT aunt trouble what   COP aunt

4          tói khá:m+bệnh ri:?
           to  hospital   PRT

           'What brings you to hospital, Trang?'

5          (1.4)

6   P:     đa:o rúa đa:o tro:::::ng (0.3) toàn       thân luôn
Trang      pain COP pain inside           throughout body PRT

           'I have pain throughout my body'

7          (0.4)

8   P:     móng+ta:i móng+chân gì: là- (.) tróc      h(h)ết
Trang      fingernail toenail  all COP     come+off  PRT

           'My fingernails and toenails have all come off'

9          (0.6)

10  P:     >cái khớp  #này# là  coai+như đa:o hết rồi¿<
Trang      CLA joint  these COP look     ache all PERF

           'These joints have been aching for ages'

11         (0.2)
```

```
12  D:    dạ::
Quynh    OK

         'OK'

         ((94 lines deleted – History-taking and physical examination))

106 D:   dạ:::(0.2) co:n      cũng có  điều+trị cho O    rồi
Quynh    OK         offspring also PST  examine  for aunt PST

107      con      biết   mà,
         offspring know   PRT

         'OK. I'm with you,¹⁶ as I've examined you before'
```

Doctor Quynh opens the consultation with a question to seek Trang's confirmation of her name (line 1). Then she initiates the problem presentation as if Trang's health concerns were new to her, and with no indication that these have, in fact, been voiced before (lines 3-4). This is particularly evident through the question marker /chi ('what'; line 3). In response, Trang pauses for 1.4 seconds (line 5), indicating that she is having difficulty responding to Quynh's question, then discloses an unspecified problem: *toàn thân* ('throughout my body'; line 6). Facing no uptake from Quynh after 0.4 seconds (line 7), Trang expands her talk to specify the problems: *móng tai móng chân* ('fingernails and toenails'; line 8) and *khớp* ('joints'; line 10). The whole presentation has a general-to-specific-description format and creates a *three-part list* (Jefferson, 1990) of current concerns as if this were the first time Trang has met Quynh: *toàn thân* ('throughout my body'; line 6), *móng tai móng chân* ('fingernails and toenails'; line 8), and *khớp* ('joints'; line 10). The pain in Trang's fingernails, toenails, and especially joints is a long-standing problem (conveyed by *rồi*, which is rendered as the present perfect progressive tense in the translation; line 10), and, as it turns out later in the extract, was disclosed to Quynh on her last visit (lines 106-107). However, Trang's presentation (lines 6, 8, and 10) shows no indication that her concerns have been voiced before. The conversation continues with the history-taking and examination of Trang's main concern: patellofemoral arthritis (data not shown). It is not until Quynh admits that she has examined Trang for the same concern before (lines 106-107) that the visit type becomes clear. The fact that Quynh knows Trang's full name at the beginning of the consultation (line 1) is not convincing enough for this to be understood as an SDF as she can retrieve the information from Trang's medical insurance paper (see Section 4.1.3). In my data set, Quynh addressed all of her patients with their full

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¹⁶ In other words, the doctor is able to follow what the patient is telling her.

names, regardless of whether the visits are first or follow-up.

Hitherto, I have analysed two SDFs in the consulting room of two different hospitals (Extracts 5.3 and 5.4). Two doctors have been shown to initiate the problem presentation differently. The first consultation (Extract 5.3) exhibits the usual pattern found in an SDF in the consulting room, whereas the second (Extract 5.4) gives the impression that the visit is new. Let us consider some possible reasons why Quynh initiated the problem presentation in this manner in Extract 5.4. Doctors in the consulting rooms see many patients every day, and they examine each patient once only, sometimes briefly. While outpatients or inpatients will return for follow-up hospitalisation after a short period, consulting patients do not follow a specific timeframe for return. They return anytime they feel necessary, such as Trang in Extract 5.4, who returns after six months. This long hiatus most likely impedes a doctor's memory of the patient's previous concern. In addition, as stated in Section 4.3, Vietnamese patients sometimes do not bring their medical record with them for the consultation. This means the doctors have no records to refer to prior to the consultation.

Within the institutional setting of the hospitals featured in the current study, doctors in SDFs to the consulting room tend to take up different epistemic stances towards different patient problems. However, given that in an SDF, doctor and patient have met at least once before, the doctor must have some access to the patient's problem. Their elicitors should ideally embody some presuppositions about the problem in question, and thus the first format, 'You have / are suffering from + [name of problem]?', can be marked as appropriate in this context. This format indicates that the doctor knows that the patient has a problem but is not certain what it is, so they do not ask the patient for a recovery assessment (an essential action in a typical follow-up visit). The remaining two formats, 'Where does it hurt?' and 'What brings you to hospital/here?', convey the doctor's lack of knowledge of the patient's problem, and thus do not seem to fit into an SDF. Therefore, we should consider how the doctor constructs a particular visit as a first or a follow-up, rather than focus on whether or not the patient has seen the doctor before for a particular problem.

5.1.2.2 Ward

The SDF patients to the wards of Hospital B are outpatients or inpatients who receive a two-week or three-week treatment course respectively. This is their first

visit after being discharged for a short period of time at home. Each is clinically attended to by a doctor, a nurse, and a hospital orderly during their hospitalisation; however, the doctor is held fully accountable for the patient's problem. The key information that doctors elicit is a recovery update relating to a particular medical problem, or a summarisation of patient concerns from their last visit to foreground the reason for today's visit. Their elicitation displays a strong claim of knowledge of the patient's presenting problem(s). The doctor's deployment of summarisation is shown in Extract 5.5 between doctor Lam and patient Sinh. In this extract, Lam recalls one of Sinh's previous concerns (i.e., backache) and asks Sinh to finalise the list. On his previous treatment course, Sinh had a back problem (line 5), which is better now (line 24). He comes to today's visit for extra acupuncture for his back and a new concern: numbness in one leg (line 71).

```
Ex. 5.5: B 3 & 24
1   D:    ↑ô:::ng
   Lam    grandpa

          'You'¹⁷

2   P:    dạ:::
  Sinh    yes

          'Yes'

3         (0.2)

4   D:    vờ:::- (0.2) trước    vô           này- (0.7)
   Lam    uh          previous hospitalise  PRT

5   D:    à::::(.) >đau cái lung nà:y,<
   Lam    uh       ache CLA back  PRT

          'Your previous concern was backache'

6         (0.3)

7   P:    vâ::ng
  Sinh    yes

          'Yes'

8         (1.1)

9   D:    rồ:i ↑chi nữa  ông     hè::?
   Lam    and  what else grandpa PRT

          'And what else?'

10  (0.6)

11  D:    [>đau kí   lung<]
   Lam    ache  CLA  back
```

'Backache'

12 P: [*truó::c là*] *vô:*   (.) *đau   kí   lu:ng*
   Sinh   previous COP   hospitalise ache CLA back

        'I had a backache during my previous hospitalisation'

13 (0.3)

14 D: *l̀ừ::: (0.2)*[*ví à:-*]
   Lam   yes   and uh

        'Yes, and'

15 P: [*#mà# chừ*] *#hắn# TÊ:*
   Sinh   but   now   it   numb

        'But it's numb now'

16 (2.0)

17 P: [*kí   chun tê:*   ]
   Sinh   CLA   leg   numb

        'My leg's numb'

18 D: [*#mà# chừ:: là #hắn#*] *tê:*
   Lam   but   now COP it   numb

        'But it's numb now'

19 (0.8)

20 P: *chừ #hắn# qua- qua- (0.3) qua   TÊ:*
   Sinh   now it   become numb

        'Now it's become numb'

21 (0.3)

22 D: *dạ:::*
   Lam   OK

        'OK'

23 (0.7)

24 P: *mà giừ::cái lu:ng ĐÕ::*
   Sinh   but now CLA back   better

        'But my back's better now'

25 (0.4)

26 D: *à:::(.) cái lung đõ:?*
   Lam   oh   CLA back better

        'Oh, your back's better?'

27 P: °*dạ:*°
   Sinh   yes

        'Yes'

        ((40 lines deleted – The patient takes medication and the doctor
        assesses previous concern))

68 D: *rúa chừ: à- (.) đợt ni ông   vô   ông*
   Lam   so today uh   period this grandpa hospitalise grandpa

69   *m- mong+muốn điều+trị cái+chi:?*
         wish   treatment what

'So what's your major concern today?'

70 (0.3)

71 P: *mong+muốn à: (.) <u>cái</u> <u>chun</u>*
  Sinh   wish   uh   CLA   leg

       'I wish to seek treatment for my leg'

       ((8 lines deleted – Talking about Sinh's leg, which is not the
       focus of discussion in this extract))

79 P: *<u>lưng</u> cũng châm   bổ+túc #nữ:a#*
  Sinh   back also acupuncture extra   PRT

       'My back also needs extra acupuncture'

       ((166 lines deleted – Taking about Sinh's problem with his leg))

245 D: *<u>ô:::ng</u> (.) rúa thì::: à (0.2) con   hoả:i lại (0.6)*
   Lam   grandpa   so COP   uh   offspring ask   again

       'Can I ask you again'

246 D: *là::: (.) hồi tr- ông   vô   bữa trước nó   là*
   Lam   COP   in last grandpa hospitalise in last that COP

247   *<u>tiền+sử</u> ông   có chi   #không#+hè::?*
         history grandpa PRT anything INT

       **'if you had any problems in your medical history when you were
       last in hospital?'**

248   (0.3)

249 D: *ông   có <u>khai</u> <u>con</u>   cái+chi không hè::?*
   Lam   grandpa PRT tell offspring anything INT   PRT

       'Did you tell me anything about your medical history?'

250   (0.3)

251 D: *ô:ng   <u>không</u> <u>bị</u> huyết+áp   hâ:y?*
   Lam   grandpa not   have hypertension INT

       'You haven't had hypertension?'

252   (0.6)

253 P: [<u>*bị*</u>-]
  Sinh   'have'

254 D: [*có*]+*không*?
   Lam   INT

       'Have you?'

255 P: *<u>bị</u>- (.) bị   huyết+áp,*
  Sinh   have hypertension

       Lines 253 & 255: **'Yes. I've had hypertension'**

While a consultation often begins with greeting or elicitation of the patient's
personal details (Byrne & Long, 1976), doctor Lam skips this step and starts the
consultation abruptly using a kinship term of address delivered in an elongated
manner and with high pitch, *Iô:::ng* ('you'; line 1), to engage Sinh in the

consultation. He does not elicit Sinh's assessment of his health concern, nor does he even ask why Sinh has returned. Rather, he reviews the previous concern in the form of a declarative turn, *trước vô đau cái lưng này* ('your previous concern was backache'; lines 4-5). The use of a *relative temporal specification* (Enfield, 2012), *trước* ('previous'), in this turn informs us that this is a follow-up visit. Also, Lam's naming Sinh's previous concern reveals Lam's prior knowledge of Sinh's problem, which suggests that Lam has a good understanding of Sinh's previous problem. Having received Sinh's alignment token (line 7), Lam enquires about other previous concerns with a request for assistance, *rồ:i ˈchi nữa ông hè::?* ('and what else?'; line 9). This question presupposes that Sinh had at least two concerns on his last visit, and that Lam is looking for the remaining one(s) (i.e., not his backache). Based on Lam's reviewing elicitors in lines 9, 11, and 14, Sinh then introduces his new concern (i.e., numbness in his leg; line 15). This practice not only updates the doctor on the previous symptoms but also informs him of the existence of new ones. From lines 28 to 67 (data not shown), the conversation returns to patient Sinh's previous concern (i.e., backache) without touching upon the new one (i.e., numbness in his leg). Realising that Sinh's backache has subsided (line 26), Lam begins to elicit Sinh's main concern, *đợt ni ông vô ông mong muốn điều trị cái <u>chi</u>* ('what's your major concern today?'; lines 68-69). On the face of it, Lam's information-seeking act in lines 68-69 indicates that this is not a follow-up visit, as Sinh's current problem, *<u>cái</u> <u>chưn</u>* ('my leg'; line 71), differs from the previous one (i.e., backache). Nevertheless, as the consultation develops, Sinh reveals that his back needs extra acupuncture (line 79). In addition, at the conclusion of the consultation (lines 245-255), Lam asks Sinh to recount his medical history in relation to his last visit. The lexical markers, *ông có <u>khai</u> <u>con</u>* ('did you tell me'; line 249), reveal that they already met each other before to deal with the same concern. Thus, the visit is clearly an SDF.

Extract 5.5 has typified how doctors in SDFs elicit patient problem presentation in this data set. First of all, there is some degree of intimacy between doctors and patients, which is reflected in the absence of a greeting at the beginning of the consultation (although not all SDFs in this study follow this pattern). This intimacy may be promoted as a result of the daily interactions between doctor and patient in the two or three weeks since the previous visit. In addition, it is through these interactions that the doctor can build their knowledge of the patient's problem.

This is indicated by the fact that their discourse largely focuses on the patient's assessment of their health after a specific point in time, and on the task of eliciting new concerns.

5.1.3 Different doctor follow-up visits

The last part in this section is about doctors' initiation of problem presentation in DDFs in the wards and the consulting rooms. Although each of these visits is termed a 'follow-up', the patient and the current doctor have not met each other before to discuss the current concern. In the follow-up, the doctor thus has to look at the patient's medical record issued by another doctor who examined the patient on their previous visit. However, as D. C. Lê (personal communication, July 26th, 2016) revealed, sometimes patients neglected to bring their medical records with them to the consultation, and sometimes doctors were too busy to read the patient's records. Therefore, doctors in DDFs sometimes interact with patient as if it were a first visit.

5.1.3.1 Consulting room

Doctors in DDFs to the consulting room often use three formats to elicit patient problem presentation. Those designing the DDF as a first visit employ two formats: 'Where does it hurt?' or 'What brings you to hospital/here?'. Their first-visit design is understandable from an institutional and social perspective. As discussed in Section 5.1.2.1, even some doctors in SDFs find it difficult to retrieve information about the patient's problem in their previous visit, especially when patients return for a follow-up after a long hiatus. Meanwhile, doctors in DDFs did not examine a follow-up patient in their previous visit; hence, their knowledge of the patient's problem can only be gained through medical records, and only if patients bring them to the visit. Otherwise, the doctor must design the visit as a first visit. Apart from these two formats, if the doctor *has* consulted the patient's medical records, they design the visit as a follow-up visit by eliciting the patient's problem(s) on their last visit. This situation is exemplified in Extract 5.6. This is patient Tam's third treatment course for his osteoarthritis at this hospital. In this consultation, doctor Nam knows that Tam is a follow-up patient (lines 1-2) but elicits Tam's previous concern as if it were a first visit (line 5).

Ex. 5.6: A 1 & 1

```
1  D:   ông     ⌐Tam  à   =>ông    đã   điều+trị    ở+đây
   Nam  grandpa Tam   PRT grandpa  PST  treatment   here

2       ⌐hai  đợt    rồi   há?<
        two   course PERF  INT

        'You've undergone two courses of treatment here before, Tam?'

3       (0.2)

4  P:   dạ::
   Tam  yes

        'Yes'

5  D:   đợt   ⌐trước đau     chi   ông?
   Nam  visit last   problem what  grandpa

        'What was the problem on your last visit?'

6       (0.2)

7  P:   dạ  =thoái+hóa+⌐khớp
   Tam  HON osteoarthritis

        'Osteoarthritis'

8       (0.2)

9  D:   à:
   Nam  oh

        'Oh'

10 P:   dạ
   Tam  yes

        'Yes'

11 D:   đợt  ni   vô            lại    cũng bị:: (0.4)
   Nam  time this hospitalise   again  also suffer

12      >đau  [chỗ  đó    luôn<?  ]
        problem part that PRT

        'You're seeking treatment for that same problem again?'

13 P:         [(dạ) hắn- hắn- hắn] ⌐có     đỡ       rồi  chừ [vô::]  (0.6)
   Tam        HON                  it      somewhat better PERF now  hospitalise

        'It's somewhat better, and now-¹⁸'

14 D:                                                        [hà: ]
   Nam                                                        oh

        'Oh'

15 P:   (cho-) >đợt   ni   mần+răng< (0.3)  điều+trị   cho    ⌐lèng   luôn
   Tam   for    course this how             treatment  so+that recover PRT

        'I  want  another  course  of  treatment  so  that  I  can  recover
        completely'

16 D:   rồi::
   Nam  OK
```

---

[18] A hyphen is used in the free translation to indicate incomplete talk or repair of the immediately preceding talk.

`'I see'`

Doctor Nam opens the visit with a declarative question on Tam's number of treatment courses (lines 1-2). Judging from this B-events question, Nam has read Tam's medical record prior to the consultation. First of all, Nam's turn design uses an alternative question ending with an interrogative particle *há* (line 2); this means that he expects a 'yes' response. Of the five alternative question types listed in Section 2.3.3.1, this one conveys the strongest stance that Tam will agree with Nam (Ngô, 1999). In addition to this is Nam's use of the numerical indicator, *hai đợt* ('two courses of treatment'; line 2). As one course would be customary before a follow-up visit, Nam's inclusion of this specific information in his turn suggests that he has read Tam's medical record. Tam's conforming answer, *dạ::* ('yes'; line 4), treats Nam's presupposition as correct.

Doctor Nam proceeds with a non-alternative question at line 5 to elicit Tam's previous concern. In contrast to his declarative question in lines 1-2, Nam's second question using the question marker, *chi* ('what'; line 5), expresses his lack of knowledge towards this concern (Heritage, 2012). In principle, there are three possible reasons why he may have asked Tam this question: (i) he did not read Tam's medical record; (ii) he is posing an *examining question* (Athanasiadou, 1991) to test whether Tam can recall his own concern (examining questions are used to test patient knowledge about something that doctors already know); or (iii) he has some knowledge of Tam's concern from his medical record, but wants to hear about it from the patient himself given Nam has not examined the patient before. Above, Nam's declarative question in lines 1-2 is designed in such a way that indicates he has most likely read Tam's medical record, so (i) can be discounted. Possibility (ii) is also ruled out by Nam's uptake (line 9) of Tam's answer (line 7); specifically, his stretched *à:*-preface (line 9) indicates that Tam's information is new to him (Heritage, 1984a). This leaves (iii) as the most plausible explanation for the weak epistemic stance that Nam expresses in his second question.

Grounded on Tam's presentation of his problem (line 7), doctor Nam begins to elicit the current concern (lines 11-12). He launches this elicitation using the words *lại* ('again'; line 11) and *đó* ('that'; line 12). These words are institutionally appropriate to follow-up visits, given that follow-ups monitor the previous concern for ongoing management of treatment (Cordella, 2001, 2004). In response, Tam's

recovery update (line 13) and his account for today's visit (line 15) make relevant a follow-up visit.

From the analysis of Extract 5.6, it can be seen that doctors in DDFs to the consulting room often have some prior knowledge of patients' presenting problems from their medical records. In possession of this knowledge, doctors tend to design their elicitors in a way that reflects this visit type, like doctor Nam did in Extract 5.6. In particular, an institutionally appropriate elicitor typically communicates that the doctor has read the patient's medical records, but still wishes to hear the patient present their problem themselves, as the doctor has not examined this patient before. This elicitor often consists of at least two TCUs: one to seek previous concerns, and one to seek the reason for today's visit. First-visit elicitors are not pervasive in the data set, so they are considered a candidate phenomenon in DDFs to the consulting room.

5.1.3.2 Ward

By and large, doctors in DDFs to the ward adopt the same formats as those in the consulting room. In addition, some of them either use the format 'You have / are suffering from + [name of problem]?', or attempt to determine the duration of the problem (see Section 6.4). These two elicitation formats indicate that the doctor has some prior knowledge of the patient's presenting problem(s), and that they are constructing the visit as a follow-up visit. In comparison with doctors in DDFs to the consulting room, those in DDFs to the ward are more likely to gain some knowledge of the patient's problem(s) prior to the consultation. This is because patients in the ward are inpatients or outpatients who often return for a follow-up visit after a short period of time. On their return visit, they have to bring their medical record with them in order to be admitted to hospital. If they leave it at home, doctors in the ward can consult the referral letter issued by a doctor in the ward right before this consultation. Therefore, the first-visit elicitation formats in DDFs may be adopted by doctors who are too busy to collect the record or referral letter from the reception (see Section 4.1.3).

Extract 5.7 illustrates how doctor Quy constructs his visit as a follow-up visit by eliciting the duration of patient Ngoc's problems. Ngoc completed one course of treatment for her contorted mouth and pounding ear, but it is not until this follow-up visit that she is able to obtain a referral letter from her previous hospital in order to

have her hospitalisation covered by her medical insurance. Quy has read Ngoc's medical record prior to the consultation taking place, so he does not elicit Ngoc's major concern. Instead, he elicits the duration of the problem (line 23).

```
Ex. 5.7: B 12 & 56
        ((11  lines  deleted  -  Talking  about  patient's  personal
        information))
12  D:   tá:i+khá:m      à¿
  Quy    follow-up+visit INT

        'This is a follow-up visit?'

13  P:   dạ:
 Ngoc    yes

        'Yes'

14  D:   mà [răng  giấy  chuyển ] mó:i ri hè?
  Quy    but why   letter referral new  PRT INT

        'Why is the referral letter new?'

15  P:       [(tái+khám)           ]
 Ngoc         follow-up+visit

        'It's a follow-up visit'

16       (1.3)

17  D:   là:::  (.) giấy  chuyển  mới ha?
  Quy    oh         letter referral new INT

        'Oh, your referral letter's new?'

18       (0.3)

19  P:   dạ
 Ngoc    yes

        'Yes'

20       (1.2)

21  P:   bệnh+viện Thống Nhất chuyển   lên¿
 Ngoc    hospital  Thong Nhat transfer up

        'I've been transferred from Thong Nhat Hospital'

22       (0.9)

23  D:   rúa bị::  ri    lâu  chưa?
  Quy    so  suffer these long INT

        'So how long have you been suffering from these problems?'

24       (0.5)

25  P:   dạ  bị     ha:i thá:ng rồi
 Ngoc    HON suffer two  month  PERF

        'Two months'
```

Right at the beginning of the consultation, doctor Quy has been informed that this is a follow-up visit through the medical record. His prior knowledge is reflected

in his first question (line 12) using the interrogative particle *à* combining with stress on *tá:i khá:m* ('follow-up visit'). This combination communicates his belief that Ngoc will agree with him (Ngô, 1999). Ngoc's 'yes' answer (line 13) treats Quy's presupposition as correct. Quy then projects another question (line 14), *mà răng giấy chuyển mớ:i ri hè?* ('why is the referral letter new?'; line 14), to search for evidence in support of his presupposition. This is a straightforward account solicitation given that the transferring letter should typically be presented on the first visit, not on the follow-up one. In launching this question, Quy is trying to call for an explanation from Ngoc. Without any response after a lengthy silence of 1.3 seconds (line 16), Quy closes off the previous question-answer sequence with a news marker, *à* ('oh'; line 17), as a sequence-closing third, following a partial repeat in an interrogative and declarative form, *giấy chuyển mới ha?* ('your referral letter's new?; line 17), to project sequence expansion (Heritage, 2018b): seeking confirmation from Ngoc. On receipt of Ngoc's confirmation of her follow-up visit, doctor Quy officially opens the visit with a history-taking question at line 23. Instead of eliciting Ngoc's chief concern, Quy asks about the duration of her problems. He employs the deictic *ri* ('these'; line 23) to refer to Ngoc's problems (i.e., contorted mouth and pounding ear), which have not been discussed so far in this consultation. This indicates that Quy has some pre-existing knowledge of Ngoc's concerns, and thus he skips the initiation of problem presentation to go directly to the history-taking stage. Of note is that eliciting information about duration only occurs in DDFs, not in SDFs as the doctors in the latter visit have looked for it in the last meeting.

While doctor Quy constructs his visit as a typical DDF to the ward, doctor Lam's elicitor in Extract 5.8 does not exhibit such obvious features. This extract is from his consultation with patient Vu, who has just finished one course of treatment for his shoulder, elbow, and left kneecap. Vu comes to this visit for the same concerns. In this extract, Lam does not know that Vu is a follow-up patient (line 18). This is probably because Lam has not had a chance to read Vu's medical record prior to the consultation (see Section 4.1.3).

```
Ex. 5.8: B 3 & 46
1   D:    rồ::::i (0.2)  anh           a- (.)  đa::u   ră:ng?
    Lam   so            older+brother  uh      trouble what
          'So, what seems to be the trouble?'
2         (1.0)
```

```
3   P:    khớp   va:i    a   bá:c,
    Vu    joint  shoulder PRT doctor

          'I have pain in my shoulder joint, doctor'

4         (0.3)

5   D:    va::i      °à°?
    Lam   shoulder   INT

          'In your shoulder?'

6   P:    với chỗ khuỷu+TA:Y ni, (.) với #cái# châ::n (0.2)
    Vu    and in elbow       this    and CLA     leg

7         [trá::i]
          left

          'and in this elbow and my left leg'

8   D:    [ừ::::]
    Lam   mmm

          'Mmm'

9         (0.6)

10  D:    #khớp#  gối     trái ha?
    Lam   joint   kneecap left INT

          'Your left kneecap?'

11        (0.2)

12  P:    dạ::
    Vu    yes

          'Yes'

13  D:    còn cái- (0.2) vai      ni   anh           (0.9)
    Lam   and CLA        shoulder this older+brother

14  D:    giở  [lên]  được không?
    Lam   lift up     can  INT

          'How about this shoulder? Can you lift it up?'

15  P:         [lên]
    Vu          up

          'Yes'

16  P:    trước là giở #không# đượ:c= mà  lên  nằm
    Vu    before COP lift not    can     but come treatment

17  rồi bữa+ni   ⌊giở [được rồ:i]
        so  now   lift can    PRT

          'Before, I couldn't lift it up. But I can now, thanks to the last
          course of treatment'

18  D:                    [lên nằm  ] chỗ+mô?
    Lam                    come stay  where

          'Which room did you stay in for your last course?'

19        (0.3)

20  P:    đâ::y
    Vu    this

          'This one'
```

Right at the outset of the consultation, doctor Lam displays a lack of prior knowledge of Vu's concerns through his general inquiry question, *anh đa::u ră:ng?* ('what seems to be the trouble?'; line 1). This launches the consultation in the manner of a first visit. The question marker, *đau răng* ('what...trouble?'), encourages Vu to provide some new information about his health condition; however, his 1.0-second pause (line 2) suggests that he is having difficulty formulating his response. Vu then lists three concerns, *khớp va:i* ('shoulder joint'; line 3), *khuỷu TA:Y* ('elbow'; line 6), and *châ::n trá::i* ('left leg'; lines 6-7). During Vu's problem presentation, Lam initiates three other questions to confirm, locate, and evaluate the symptoms of the pain (lines 5, 10, and 13-14), and is able to obtain further information about Vu's previous visit, *lên nằm* ('last course of treatment'; line 16).

Patient Vu's three concerns related to his shoulder joint (line 3), elbow (line 6) and left leg (lines 6-7) are disclosed as if they were unknown to Lam. This is also verified through Lam's modified repeats of Vu's responses in order to seek Vu's confirmation (lines 5 and 10). The actual visit type becomes discernible from line 16 onwards, when Vu makes an assessment of his recovery in order to inform Lam that he has come for treatment before. On receipt of Vu's information, Lam does not wait until the TRP (i.e., the particle *rồ:i* at line 17), but starts his turn early to project a non-alternative question (line 18), engendering a terminal overlap onset with Vu's turn (line 17). Lam's non-alternative question, *lên nằm chỗ mô?* ('which room did you stay in for your last course?'; line 18), communicates his lack of knowledge of Vu's previous treatment course. Moreover, Vu also designs his responses as if he has not presented to Lam before (lines 3 and 6-7). We can conclude that Lam did not treat Vu on his last visit, and that the present visit is a DDF.

Extracts 5.7 and 5.8 have displayed two different practices of organising the problem presentation stage in DDFs to the ward. While doctor Quy in Extract 5.7 employs a history-taking question to initiate the patient's presenting problem(s), doctor Lam in Extract 5.8 uses a general inquiry question. The elicitation design employed by each doctor is largely shaped by their prior knowledge of the problem(s) in question. Note that, while doctor Lam has not read the medical record or referral letter before the consultation, doctor Quy has done this. Therefore, a typical elicitor in DDFs to the ward conveys the doctor's access to the patient's concern(s), as in Extract 5.7.

In conclusion, doctors in first visits, SDFs, and DDFs to the consulting room and the ward design different types of questions in the course of initiating patient concerns. Their turn design is based on their epistemic stance towards the patient's concerns, which is, in turn, partly constrained by the institutional context of the Vietnamese hospital. Of all the visit types, only doctors in first visits to the consulting room and SDFs to the ward consistently adopt appropriate elicitors. The appropriateness of doctor elicitors in the remaining visit types and locations are (apart from the institutional issue) contingent on whether patients bring their medical records to the consultations or not, and on the issue of how much doctors know (or are expected to know) about the patient's history. This is something for both participants to establish during the consultation. To put it differently, in designing their initial solicitations in particular ways, doctors convey a certain epistemic stance towards the patient's problem which may or may not be accurate, as far as the facts go. Therefore, the existence of different visit types above may be traced to the issue of medical records. First of all, patients sometimes neglect to bring their medical records with them to the visit (e.g., Extract 5.3). Even if their records were available, some doctors in this study were too busy to read them before the consultations took place, especially doctors in the wards. Those in the consulting rooms might have read the medical records. Unfortunately, due to the lack of videorecorded data, I could not tell how much the doctors read these records, and whether the records were being read during or prior to the visit.

5.2 Patient disclosure

In the present study, patients deploy different strategies to present the reason for their visit. The patient problem presentation often lies in the second-pair part of the problem presentation sequence, in response to the doctor first-pair part. In particular, the patient problem presentation comes directly after the doctor's opening questions, as these give patients an opportunity to articulate their decision to seek medical assistance. During that opportunity, patients are institutionally licensed to express their own ideas in accordance with their planned agendas. By presenting their concerns to doctors, patients raise the issue of doctorability in order to legitimise their visits (Heritage & Clayman, 2010), thus making a request for service and seeking an expert's advice for their health-related problems (Ijäs-Kallio et al., 2010). To this end, they have a range of choices regarding both the content and the

formulation of concern presentation. In Pomerantz's (2002) terms, patients may describe symptoms, provide a narrative of their experiences with the symptoms, and reveal their lay diagnosis. Alternatively, according to Stivers (2002b), patients may take advantage of this opportunity to express their levels of concern, their theories of what is wrong, and whether and how they think the problems should be dealt with. Via these strategies, their presentation conveys a tension between their lay evaluation and the doctor's expert judgment (Heritage & Robinson, 2006a). Overall, along with the description of symptoms, the problem presentations can also feature the patient's feelings through their explanations of the problems.

Here I do not foreground the patients' practices according to the visit types as I have done in Section 5.1, since the same practices occur in all types of visit. Rather, I make visible their presentations according to the strategies used. There are six strategies of presentation: symptoms-only presentation (Section 5.2.1), presentation plus self-diagnosis (Section 5.2.2), presentation plus assessment (Section 5.2.3), presentation plus cause (Section 5.2.4), presentation plus reason for choosing this hospital (Section 5.2.5), presentation as a narrative (Section 5.2.6), and presentation without being elicited (Section 5.2.7). These problem presentation formats are either designed as such from the outset, or emerge interactionally (in that they are shaped by doctor elicitors).

5.2.1 Symptoms-only presentation

Symptoms-only presentation refers to the presentation of a concern in which the patient describes their biomedical and/or psychosocial problems, the location (of any biomedical problems), or their duration. Two formats for this presentation type are identified: general-to-specific presentation, and listing of problems. A general-to-specific presentation is often composed of at least two TCUs: the first names the major problem, and the second elaborates on it by describing the symptoms or naming other related minor ailments (e.g., Extracts 5.1 and 5.4). Listing of problems is used by patients who have more than one concern, and they list all concerns either in the same or a different turn (e.g., Extracts 5.4 and 5.8). The general-to-specific practice is illustrated in Extract 5.9 between doctor Quynh and patient Bich. Bich comes to this visit with four concerns: leg, shoulder, neck, and arm pain. However, in this extract she presents one concern only (i.e., leg pain; line 10); the remaining three concerns are disclosed after Quynh finishes eliciting all relevant information of

the first concern.

```
Ex. 5.9: B 1 & 3
        ((Talking about patient's personal information))

6  D:    rồi   chị          ừ:- (.) chừ:: chị:         ĐAU    cái chỗ+mô
Quynh    so   older+sister uh       now  older+sister concern at  where

7        =chị          nói em            nghe
         older+sister tell younger+sister hear

         'So, tell me about your health concerns, please'

8        (0.2)

9  P:    chị          đau- (.) chừ mà  đau  nhiều+/nhứt (.) là  nơi
Bich     older+sister hurt     now COP hurt most            COP in

10       cái chân
         CLA leg

         'It hurts- this leg hurts the most now'

11 P:    =từ  nơi về   ni   hây (.) chị          muốn mà  co   cái
Bich     from at  thigh this PRT     older+sister want to  bend CLA

12       chân lên là  chị-        em            biết chị          phải
         leg  up  COP older+sister younger+sister know older+sister must

13       xách cái- (.) ri ri       này (.) chị          mới
         raise CLA        like+this PRT     older+sister PRT

14       bỏ   lên ri       được
         lift up  like+this can

         'This thigh, you know, I must raise it like this if I want to bend
         my leg and lift it up'

15       (.)

16 P:    chơ #không#+thôi cái chân #hắn# đau
Bich     if  not         CLA leg   it    hurt

         'If not, my leg hurts'
```

After five lines of securing Bich's personal details (data not shown), doctor Quynh opens the visit with a *Tell me about X* format (Heritage & Robinson, 2006b) in lines 6-7. Bich takes this general inquiry question as an invitation to introduce the reason for the visit. After a brief silence (line 8), Bich gives a presentation of her major concern: leg pain (lines 9-14 and 16). She makes a self-initiated repair at the outset of her turn by replacing *chị đau-* ('it hurts') with *chừ mà đau* ('this leg hurts … now') to add the temporal context, *chừ* ('now'), for the pain (line 9). Additionally, she puts an emphasis on the intensifier *nhiều /nhứt* ('the most'; line 9) with a sharp change upward in pitch at the second word, */nhứt* ('most'), in order to highlight the severity of the problem. The lexical items, *chừ* ('now') and *nhiều nhứt* ('the most'; line 9), also imply that she has more than one concern, but leg pain is the

most serious one at the moment. Apart from its purpose of intensification, Bich's choice of *nhiều nhứt* ('the most') alerts Quynh that some less serious concerns are likely to be revealed later. The major location of pain (i.e., leg) is pinpointed after a micro pause (line 9). This turn structurally and semantically reaches its possible completion point at *chân* ('leg'; line 10). Despite this, Bich rushes through this TRP (i.e., marked by an equal signal at line 11) to disclose the information about symptoms (lines 11-14). She both details and models her leg pain by a basic movement to demonstrate its severity. This expanding talk serves as a justification for her claim. Bich closes the presentation sequence with a contrasting marker, *chớ #không# thôi* ('if not'; line 16), to stress the pain severity.

In this extract, patient Bich formulates a general-to-specific presentation in a three-TCU turn. The first TCU provides general information by locating the pain area (lines 9-10). In the second TCU, she details the pain through a quick demonstration of how it affects her ability to move her leg. The third TCU adds emphasis to the pain severity. This general-to-specific description clearly presents the main concern right at the beginning of the consultation, thus providing doctors with a straightforward account for the visit. Through this presentation, doctors can grasp and evaluate the main point quickly and thoroughly, which may facilitate their elicitation of further information later.

5.2.2 Presentation plus self-diagnosis

The patients' demonstration of their medical knowledge is prevalent throughout my data. As described in Section 4.2.2 (see Appendix B as well), the patients in this study come from different walks of life. A large number of them are blue-collar workers, although some are white-collar workers. In the latter cohort, there are experts in medicine, whose medical knowledge has been gained as a result from their formal training. Nevertheless, many non-professional patients also exhibit lay knowledge of their problems. Their knowledge base has been built on their own experiences of long-term suffering, what they have learnt from social media, information from third parties or patient advocacy groups (Hall & Roter, 2006), and so on. This information is volunteered, or provided in response to the doctor's elicitation. The most common ways in which patients demonstrate their lay knowledge are by offering a self-diagnosis, or disclosing information about self-treatment.

Despite having some sort of diagnosis, patients are often guarded in bringing up a diagnosis in the consultation. Patient self-diagnosis claims doctorability and triggers the doctor's moves towards the next steps of the consultation (Heritage & Robinson, 2006a). Pomerantz (2002) argues that patient disclosure of diagnosis is shaped by, and in turn shapes, the patient's role identity and local project. In other words, by offering a diagnosis, patients not only involve themselves in the treatment process but, to some degree, also raise their expectation of the outcome. Hence, these consultations are much more patient-centred (McWhinney, 1989).

In this study, the common format used for offering a diagnosis is by naming the problem. This is deployed in two ways: making their own diagnosis, or invoking the diagnosis of a third party (e.g., a previous health practitioner). Patients can design their diagnosis as a response to the doctor elicitation of the problem presentation, or as an expansion of their description of symptoms in the same turn. Consider how patient Dinh in Extract 5.10 cites an earlier diagnosis of his degenerative spinal condition (lines 16-17) when responding to doctor Yen's elicitation in the inpatient ward. Dinh has had chronic back pain for six years, but this is the first time he has been to hospital (data not shown).

```
Ex. 5.10: B 13 & 70
        ((Talking about patient's personal information))

12 D:    mình đau  chi  mà vô+viện    ri  anh?=
 Yen     you  pain what COP hospitalise PRT older+brother

        'What brings you here?'

13 P:    =<Bị thắt+lung
Dinh     pain waist

        'Pain in my waist'

14       (0.7)

15 D:    dạ (0.2) bị-=
 Yen     HON      pain

        'Pain-'

16 P:→   =dạ: (0.2) bị (       ) =bị  thoái+hó-   (0.7)
Dinh     HON                      have degeneration

17       à  >THOÁI+HÓA   CỘT+SỐNG<¿
         uh degeneration spine

        'I have (   ), have degeneration- spinal degeneration'

18       (0.5)

19 D:    thoái+hóa    cột+sống¿
 Yen     degeneration spine

        'Spinal degeneration'
```

Upon receiving doctor Yen's general inquiry question (line 12), Dinh makes a *jump-started talk* (Schegloff, 2005; the '<' symbol at line 13) to present his main concern: =<*Bị thắt lưng* ('pain in my waist'; line 13). Jump-starting is a practice by which a speaker starts their talk that sounds earlier than it is and has an over-loud first syllable (Schegloff, 2005). After a 0.7-second silence (line 14), his information is minimally receipted by Yen, who most likely orients to a repeat of Dinh's response, but then abruptly cuts herself off at *bị-* ('pain'; line 15) when Dinh immediately puts forward the diagnosis (lines 16-17), *THOÁI HÓA CỘT SỐNG* ('spinal degeneration'). This works to clarify his previous presentation at line 13 and respond to Yen's cut-off talk at line 15. After 0.5 seconds of silence (line 18), Yen leaves Dinh's diagnosis unassessed by repeating the information (line 19).[19] The absence of Yen's assessment at this problem presentation stage probably means that she wants to move the diagnosis to its own stage after history-taking and physical examination. This reflects her orientation to the canonical organisation of the medical visit (Gill & Maynard, 2006).

In this extract, patient Dinh presents the diagnosis overtly by naming the problem using the medical term *thoái hóa cột sống* ('spinal degeneration'; line 17). Although he has never sought treatment at any health centres before (data not shown), Dinh is able to know its cause and put forward a clear diagnosis through "highly moral language with no mitigation" (Pomerantz, 2002, p. 132). The sociological background of his presentation lies in his experience with this chronic pain, which, as he reveals later, has recurred once a year over a period of six years (data not shown). Due to such frequent recurrences, Dinh has grasped its symptoms and implemented some temporary treatments like coin rubbing, applying medicated oil, or taking pain relievers prescribed by pharmacists (data not shown). In addition, his visit takes place in the inpatient ward and Dinh has to undergo an overall examination by a doctor in the consulting room first. It is probably through this earlier examination that he was informed of the diagnosis.

Patient disclosure of a self-diagnosis is a common practice in this study. This practice occurs throughout the consultation, but most often in the problem presentation stage when patients describe their symptoms. Most of their diagnoses come from third parties, that is, from test results or health practitioners in their

---

[19] The next talk is about pain duration and previous treatment (data not shown).

previous consultations (e.g., Extract 6.4). In addition, those who have suffered from their pain for a long time can also make a self-diagnosis of their problem based on their experience. In the cases above, the self-diagnoses tend to be straightforward without any mitigation or hedging devices. However, patients with an acute problem sometimes disclose their own lay self-diagnosis. In this case, they design their turn in a way that conveys uncertainty about their claim. Through disclosing their self-diagnosis, patients establish the reason for today's visit or speak with the voice of medicine, which is always considered the possession of doctors (Mishler, 1984). On the one hand, they signal that it is not only the doctors who have such expertise. On the other, they want to demonstrate their knowledge of the field and show their understanding of, or responsibility for, their own health. In portraying their claims, patients seek entitlements for their medical knowledge to be sanctioned.

5.2.3 Presentation plus assessment

Patients' assessments of their problem typically occur in two ways. They are given when doctors ask patients to update their health recovery after a course of treatment, or patients integrate assessments into their problem presentation. During the history-taking and physical examination phases, patients also volunteer their assessments in response to doctor elicitation of symptoms or past treatment (see Section 6.1). These assessments update doctors on the patient's health condition or provide insight into past treatment plans.

Presentation plus assessment is characteristic of follow-up visits, regardless of whether it is an SDF or a DDF. This pattern sometimes occurs in first visits when the patient has already received treatment at another health centre. Patients often construct their presentation plus assessment in a multi-unit turn. Firstly, they present their current problem. Then they assess their recovery since the last visit/ hospitalisation. Sometimes they raise a new concern(s), if there is one. Extract 5.11 illustrates how patient Thuy integrates her assessment into a multi-unit turn in response to doctor Tuan's elicitation of problem presentation. After presenting her main concerns of backache and swollen knees (lines 3-5), Thuy discloses her assessment to update Tuan on her health condition (lines 7-8).

Ex. 5.11: A 2 & 15

```
1 D:      chừ mệ      đau  chỗ+mô::?
Tuan      now grandma hurt where
```

```
        'Where does it hurt?'

2       (1.0)

3 P:    nói+chung  đa:u (0.5)  lu::ng (0.2)  #hắn-# h- cứng
Thuy    mainly     ache        back          it       stiff

4       lu::ng (0.2) xuống hai  đầu+gúi  ni    h- (.) hắn  su:ng
        back         down  two  knee     these        they swell

5       (0.2)  #hắn#  sung   °rứa°
               they   swell  PRT

        'It's mainly backache. My back's stiff all the way down to my
        knees, which have swollen, swollen up'

6       (0.6)

7 P:    nhưng  #hắn#  có:: (0.2) ha-  hắn  có   bót   được  năm+mươi
Thuy    but    they   PST              they PST  back  PRT    fifty

        'But they're back to fifty percent of normal'

8 P:    =còn   năm+mươi
Thuy    still  fifty

        'There's still fifty percent left'
```

In his question, *chừ mệ đau chỗ mô::?* ('where does it hurt?'; line 1), doctor Tuan asks about the pain location, thereby indicating that the concern is new to him. He does not ask Thuy to assess the pain condition after she was discharged from the hospital. Thuy postpones her response after a long silence of 1.0 second (line 2), which treats Tuan's questions as inappropriate in this follow-up visit. She then pinpoints the pain location (lines 3-5) by prefacing her turn with *nói chung* ('mainly'; line 3); this alerts Tuan to the fact that the imminent talk will summarise her main concerns, and that it is likely that there are other minor concerns as well. Thuy pauses for 0.5 seconds (line 3) before naming the pain location, *lưng* ('back'; line 3). She then briefly pauses again (0.2 seconds) and reports its symptom, *hắn cứng lưng* ('my back's stiff'; lines 3-4). After another brief pause of 0.2 seconds (line 4), Thuy raises one more problem, *hai đầu gúi* ('my knees'; line 4) and the symptom, *sưng* ('[my knees have] swollen up'; line 4). She repeats *hắn su:ng* ('[my knees have] swollen up'; lines 4-5) after 0.2 seconds (line 5) and stresses *sưng* ('[my knees have] swollen up') twice, which aims to increase the perceived severity of the problem. Once the main concerns are presented without any feedback from Tuan after a silence (line 6), Thuy expands her presentation to volunteer her assessment of the pain recovery (lines 7-8). She prefaces her assessment turn with a contrastive marker, *nhưng* ('but'; line 7), to draw attention to the fact that the imminent talk will contrast with the previous information. The words *bót* ('back'; line 7) and *còn*

('still'; line 8) communicate that her problems have received treatment before, and thus this follow-up visit is to monitor the remaining fifty percent (line 8).

Extract 5.11 has presented a typical example of how patients design their turns in such a way that they can incorporate a recovery update into their presentation. It can be seen that this information is not elicited by doctor Tuan, but volunteered as an expansion of Thuy's presenting problem(s). In the first TCU of her multi-unit turn, Thuy describes the symptoms of her back and kneecaps, and then discloses their progress in the remaining TCUs. Her volunteering information informs Tuan that this is a follow-up visit, given Tuan's inappropriate elicitor. In doing this, Thuy works to orient the trajectory of the consultation in the manner of a follow-up visit.

5.2.4 Presentation plus cause

During the course of problem presentation, instead of waiting for the doctor's elicitation, patients also offer their own lay explanations for what they think is causing their ill-health. These explanations can be regarded as narrative accounts which detail the patient's symptoms and the difficulties they are experiencing or have experienced, and which may be proposed overtly or tacitly. According to Gill and Maynard (2006), patients connect their explanations with their presentation of concerns through *linkage proposals*, which range from attributive (i.e., overt proposal) to non-attributive (i.e., tacit suggestion).

Extract 5.12 illustrates how an overt proposal is brought forward by patient Mai. Mai has pain in her spine, the cause of which she traces to a car accident (line 8) and physically-demanding tasks (line 15; see Section 6.3 for causes of the problem).

```
Ex. 5.12: A 1 & 2
1 D:      mệ      đau  chi  #mà# vô    đa:y?
 Nam      grandma pain what COP   come here

          'What brings you here?'

2         (0.5)

3 P:      °dạ::° (0.6) khi+TÊ:: a  là:::(0.2)°là° bổ:
 Mai      HON          past    PRT             COP fall

          'I had a fall in the past'

4         (1.0)

5 D:      bổ::?=
 Nam      fall

          'A fall?'
```

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```
6 P:     =lối kì   Ngụy bổ̀::  (.)  bò- (0.4)
 Mai      at   time Nguy fall      and
```

         'During Nguy time[20], I had a fall and–'

```
7 D:       [ừ:]
 Nam        mmm
```

         'Mmm'

```
8 P:→    >[à:] #không#+phải bổ̀< (.)  xe  tô:ng,
 Mai      uh    not          fall     car hit
```

         'I didn't fall, but was hit by a car'

```
9        (0.3)
```

```
10 D:    ừ::
 Nam     mmm
```

         'Mmm'

```
11       (0.2)
```

```
12 P:    *ạ:*
 Mai     yeah
```

         'Yeah'

```
13       (0.4)
```

```
14 P:    bơ nằm+bệnh+viện (.) a- (0.2)  mà: chừ: là:::::nh (.) mà- (0.2)
 Mai     and hospitalise       PRT          and now recover         but
```

         'and I was hospitalised for treatment, so I recovered, but'

```
15 P:→   chừ- (0.2) năm ngoá::i chừ (0.2) là  đi  gá:nh mù #hắ::n# (0.8)
 Mai     now        year last   now       COP work carry so it
```

         'last year, I carried heavy loads so'

```
16 P:    lối  nó: (1.0)  xe  tông mí  trật  xương+sống
 Mai     time that       car run  PRT sprain spine
```

         'At Nguy time, a car ran into my spine and sprained it'

```
17       (0.3)
```

```
18 D:    ừ:::
 Nam     mmm
```

         'Mmm'

```
19       (0.4)
```

```
20 P:    ạ::
 Mai     yeah
```

         'Yeah'

```
21       (0.3)
```

```
22 D:    à::
 Nam     oh
```

         'Oh'

```
23 P:    là::-
```

---

[20] *Ngụy* refers to a period preceding April 30th, 1975, when a government called the 'Republic of Vietnam' ran southern Vietnam (from Quang Tri to the whole southern regions).

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```
      Mai    uh

             'Uh'

24 D:        trật   xương+số:ng?
   Nam       sprain spinal

             'A spinal sprain?'

25           (0.3)

26 P:        dạ: (.) trật   xương+sống  mà  chừ mà  #hắ::::n# (1.3)
   Mai       yes     sprain spinal      and now COP it

             'Yes, it was. And it'

27 P:        đa:::u  bờ  chừ::- (0.4) kí+ni::: (0.2) năm  ngoá:i
   Mai       hurt    and now          this          year last

             'hurts now, and last year'

28 P:        bờ  gá:nh (0.3) bờ  #hắn#  trật   lạ::i
   Mai       PRT carry        so  it    sprain again

             'it got sprained again because I was carrying heavy loads'

29           (0.4)

30 D:        à:: (.) chừ cũng [đau  xương+sống ] lạ:i?
   Nam       oh      now also pain spinal       again

             'Oh, the spinal pain's recurred now?'

31 P:                         [bờ   gánh-      ]
   Mai                         and  carry

             'And I carried heavy loads'

32 P:        dạ: (0.2) >#hắn#  đau  nớ   lại<
   Mai       yes       it     pain that again

             'Yes, that pain's recurred'
```

At the outset of the visit, doctor Nam raises a general inquiry question to seek Mai's main concern (line 1). After a delay of 0.5 seconds (line 2), Mai begins her presentation with *khi tê* ('in the past'; line 3) as an attributive linkage proposal to refer to a past accident, *bổ* ('a fall'; line 3). After 1.0 second of silence (line 4), Nam makes a partial, virtually identical, final-rising-intoned repeat of Mai's response to treat *bổ::?* ('a fall'; line 5) as an other-initiated repair (Robinson & Kevoe-Feldman, 2010; Schegloff et al., 1977). It is an other-initiated repair because the repair is initiated by Nam, not by the participant who makes the trouble source (i.e., Mai). Mai immediately responds by repeatedly emphasising *bổ::* ('a fall'; line 6) and specifying the time reference *kì Ngụy* ('Nguy time'; line 6) to reinforce her answer, but later corrects the cause, *xe tông* ('[I] was hit by a car'; line 8). On receipt of Nam's continuer (line 10), Mai further narrates the previous treatment *nằm bệnh viện* ('I was hospitalised for treatment'; line 14) and the recovery of her problem. She

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then adds another cause which occurred last year, *đi gánh* ('I carried heavy loads'; line 15). After another pause (line 15), Mai discloses the main problem, *trật xương sống* ('[a car] sprained [my spine]'; line 16), and repeats the first cause: a car accident (line 16). Nam concludes the problem presentation sequence with an inference about Mai's main reason for today's visit, *đau xương sống lạ:i* ('the spinal pain's recurred'; line 3430).

In Extract 5.12, patient Mai traces her problem to two main causes: an accident (i.e., an impact with a car) and physically-demanding tasks (i.e., she was a street vendor who used to carry heavy loads). Although this is her first visit to this hospital, Mai is able to identify the causes. First of all, she is likely to have sought treatment elsewhere in the past, as this ailment first struck her 40 years ago and recurred last year. It may be through these treatments that she was informed of the causes. Moreover, this problem, by virtue of its long duration, is deemed a chronic one. This means she may have attempted to determine its cause herself. In short, her claim is probably based both on her own lay knowledge and on the expert knowledge of other health professionals. In addition, the fact that Mai presents a series of causes before naming her problem reveals her indirect manner of problem presentation. Instead of presenting the problem outright, she provides a narrative of her past incidents to foreground the reason. This indirectness, to some extent, reflects the communication style of Vietnamese people (DeBonis, 1995).

5.2.5 Presentation plus reason for choosing this hospital

As mentioned in Section 4.1.1, the first contact point for most insured patients is a communal or district health centre, or a private medical centre; however, the two hospitals where the current research took place are at the provincial level. Additionally, Vietnamese patients typically only come to see a doctor when their problem becomes very serious (N. T. H. Phạm, 2014; P. X. Trần, 2013). Last but not least, a large number of the participating patients (60.6%) come from small towns or villages (see Appendix B), which are far from the research sites. The above information implies that patients may seek treatment at other health institutions before they arrive at the research hospitals. Therefore, doctors wish to know why patients have come to them and what they expect, while also evaluating patients' healthcare habits. This practice often emerges in the first visit or DDF where doctors and patients have never met before for the same concern.

Not only do doctors wish to elicit the reason for choosing this hospital, but patients volunteer this information as well. Along with presenting their major concern, patients establish various reasons for choosing the current hospital. For instance, some have been recommended by a relative or a medical expert, some prefer the treatment regime on offer, and some have been referred to this hospital by another health centre of a lower level. However, most of the patients in this study explained their choice as dissatisfaction with treatment at a previous health centre. Their reasons are mostly volunteered rather than elicited, and they tend to come later in the problem presentation sequence, after the main problem has been disclosed. This is demonstrated in Extract 5.13 in which patient Hanh overtly discloses to doctor Nam that her choice of this hospital is due to the non-recovery of her problem after receiving treatment at Thong Nhat Hospital (arrowed). Hanh has pain in her shoulder and rib and this is her DDF.

```
Ex. 5.13: A 1 & 3
1  D:    mệ::  (.) đau  cái vùng chi  mà:: (.) vô   đây  điều+trị?
   Nam   grandma   hurt CLA area what that    come here treatment
         'What brings you here?'

2        (1.0)

3  P:    dạ:::::: (0.4)#hắn# đau  kí  va::i   ni   bá:c
  Hanh   HON           it   hurt CLA shoulder this doctor
         'This shoulder hurts, doctor'

4        (0.2)

5   D:   [đau va::i    °à°?]
   Nam   hurt shoulder INT
         'Your shoulder?'

6  P:    [với cái sườ::n   ]
  Hanh   and  CLA rib
         'and my ribs'

7        (0.8)

8  P:    với là: (.) cái SƯỜN này  nó bị:: a::::(1.1) loãng+xươ:::ng (0.3)
  Hanh   and COP     CLA rib  this it have uh         osteomalacia
         'also, my ribs have osteomalacia'

9   D:   [à::]
   Nam   oh
         'Oh'

10 P:    [chỗ] cái- cái xương+bì:,
  Hanh   inside     CLA bone
         'Inside the bone'
```

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```
11       (0.4)

12  D:    cái  xương+[đùi     ] bên  đó   đo  hi:?
    Nam   CLA  bone             side that PRT INT

          'You mean that bone?'

13  P:                 [và:::::-]
    Hanh               and

          'And'

14  P:    dạ:::
    Hanh  yes

          'Yes'

15       (0.2)

16  D:    [°ừ:°]
    Nam   mmm

          'Mmm'

17  P:→   [mà ] đi- đi   khá::m    à:::  (0.2) tui có  nằm+việ:n  à:::  (.)
    Hanh  but      seek treatment uh            I  PST hospitalise uh

18       Thống  Nhấ:::t (0.7) HAI+mươi ngày đó mà::- (0.3)  cứ   uống
         Thong  Nhat         twenty   day  PRT but          just take

19       thuốc      không+thôi, =cho+nê::n (.) là  nó  không  đỡ::,
         medication only         so             COP it  not    go

          'But I sought treatment- I was hospitalised at Thong Nhat Hospital
          for twenty days, but I just took Western medication so the pain
          hasn't gone'

20       (0.4)

21  D:    ừ::
    Nam   mmm

          'Mmm'

22  P:→   ấy  tôi mới XIN về        đâ:y (0.2) #tôi muốn#  là: co:::i (0.7)
    Hanh  so  I   PRT ask transfer here       I    desire COP check

23       #nó# đau  cái  xương+bì này  mà nó đau  cái lưng
         it   hurt CLA  bone     this COP it hurt CLA back

24       xương+[sống ⌈quá chờ::i i:: ]
         spine       very lot  PRT

          'So I asked for a transfer to this hospital to have my ribs
          checked. This bone, my back, and my spine hurt a lot'

25  D:        [à:::à: (hắn)     ] có   [nhiều] hí:
    Nam        oh  oh they          very  much   PRT

          'Oh, oh, they're very painful'

26  P:                                     [dạ:  ]
    Hanh                                    yes

          'Yes'
```

The problem presentation sequence is initiated with a general inquiry question from doctor Nam which marks this consultation as a first visit. In response, Hanh names the problem of her shoulder and ribs plus a diagnosis of the latter (lines 6 and

8). After several turns about the bone inside her ribs, Hanh discloses further information about treatment (lines 17-19). She constructs this turn in the form of a narrative about her past treatment at another health centre. She discloses the name of the health centre, *viện Thống Nhất* ('Thong Nhat Hospital'), to set the scene for her narrative. Then she states the duration, *hai mươi ngày* ('twenty days'), names the treatment plan, *cứ uống thuốc* ('[I] just took Western medication'), and evaluates its outcome, *không đỡ* ('the pain hasn't gone'). Through this assessment, she implies that the traditional treatment methods of this hospital may work better to treat her problem. Via this contrast marking, she shows her preference for the treatment at the current hospital. This is expressed in her following chunk of information about the reason for seeking treatment at this hospital (lines 22-24). Given that the current hospital can meet her preferences, Hanh continues the narrative by upgrading the role of this hospital, *ấy tôi mới xin về đây* ('so I asked for a transfer to this hospital'; line 22). In the rest of her turn, she expresses her expectation, *tôi muốn là coi* ('[I asked for a transfer to this hospital] to have my ribs checked'; line 22), then increases the perceived severity of the problem (lines 23-24).

It is notable that in addition to presenting her problem, patient Hanh also adopts the practice of elaborating on her response to emphasise the severity of her problem. This is a common practice during problem presentation in my data. In doing this, patients alert doctors that their pain is serious and thus it is in need of urgent treatment. For first visits, this action puts pressure on doctors to make current treatment recommendations that will be effective so as to alleviate the pain. For follow-up visits, it implies the ineffectiveness of doctors' previous treatment plans, which thereby means an alternative one is expected.

Extract 5.13 has demonstrated how patient Hanh elaborates on her presentation by providing a reason for choosing this hospital, even though this information is not elicited by doctor Nam. This elaboration is effectively deployed by means of various linguistic and interactional resources, such as the long duration of her hospitalisation at Thong Nhat Hospital, the reason for the negative outcome, the suffering she has had to endure, and emphasis on some key words in lines 17-19 and 22-24. Via this course of action, Hanh seems to be using her treatment history at another hospital to further establish the doctorability of her problem and to emphasise its severity. In other words, her assessment is presented as a reasonable and legitimate basis for her visit.

Hitherto I have illustrated medical consultations where patients present their problem, provide causes, deliver self-diagnosis, and disclose the reason for their choice of the current hospital. However, there are occasions when patients present all of this information at the same time. This is designed in the form of a narrative.

5.2.6 Presentation as a narrative

Together with naming their problem, some patients construct a narrative sequence of symptom discovery to establish their reason for the visit. A narrative refers to the patient's telling of a story which has time reference to different events in the past. This practice provides a detailed picture of their problem history as a whole, as seen in Extract 5.14. Similar to the practices discussed so far, doctors do not actually elicit these types of information. Rather, they are volunteered by the patient. Extract 5.14 is a first visit between doctor Si and patient Huy. Huy is a teacher of physical education who does exercises regularly to treat the chronic problem in his upper shoulder and waist. Throughout this extract, Huy designs his presentation of those two concerns in the format of a narrative (lines 6-7, 14-15, 17, 20-22, 24-27, 29, 34-35, 37-38, 43, 44-46, 48-50, 59-60, and 62-65).

```
Ex. 5.14: B 8 & 31
        ((Talking about the patient's name))

4 D:    anh           đau      răng °anh°?
  Si    older+brother trouble what older+brother

        'What seems to be the trouble?'

5       (0.6)

6 P:    à: (.) anh           điều+trị  ri là::-/là (0.4)
 Huy    mmm   older+brother treatment PRT     COP

7       /hai lần hè    rồi.
        two  CLA summer PST

        'Mmm. I underwent two courses of treatment over the last two
        summers'

8       (0.5)

9 D:    điều+trị   ở+đây?
  Si    treatment here

        'At this hospital?'

10      (0.2)

11 P:   ò:
 Huy    yeah

        'Yeah'

12      (0.3)
```

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```
13 D:    hà
   Si    oh

         'Oh'

14 P:    mờ- mờ: (0.2) lần hè    ni:- là  tại+vì (0.2) quá ↑đau
   Huy   but          CLA summer this COP because     so  pain

15       luôn bờ- bờ- bờ anh          phải- vô          lại
         PRT             so older+brother must  hospitalise again

         'But because the pain came back, I have to go to hospital again
         this summer'

16       (0.4)

17 P:    cái ĐAU  thứ+nhất là cí- cí- cí (.) cái >VAI     GÁY    ni    nầy<
   Huy   CLA pain first    COP              CLA shoulder upper this PRT

         'My first problem's the pain in my upper shoulder'

18       (0.7)

19 D:    dạ=
   Si    OK

         'OK'

20 P:    =là:: (0.7) mỗi   lần  anh            ngồi: (0.2) nơi máy
   Huy    COP        every time older+brother sit        at  computer

21       mình làm+việc a (0.8) là  #hắn# tê:+buốt luôn (.) #hắn# nhức-
         I    use       PRT    COP it    stiff    PRT       it    painful

22       mà- mà (0.2) thị+lực anh            là  không ↑thấy luôn,
             COP      eyesight older+brother COP not    see   PRT

         'Every time I use the computer, my upper shoulder is so stiff and
         painful that I can't see a thing'[21]

23       (0.6)

24 P:    là #một# cái thứ+nhất=cái thứ+hai nữa là (0.4)
   Huy   COP one  CLA first    CLA second  PRT COP

         'That's the first problem. The second is'

25 P:    ừ  (0.6) h- hă- hắn bị       đau #nơi# ↑thắt+lưng a (0.7) đau
   Huy   uh              it suffer pain in    waist    PRT       pain

26       thắt+lưng a  =thì vừa+rồi anh            có đi: (.)
         waist     PRT then recently older+brother PERF go

27       xin chụp+phim
         have X-ray

         'the pain in my waist, pain in my waist. I've had an X-ray for it
         recently'

28       (1.1)

29 P:    kết-+quả phim  đây
   Huy   result   X-ray here

         'Here's the X-ray result'

30       (0.2)

31 D:    °dạ:°
   Si    OK
```

---

[21] Presumably the pain in his shoulder is so severe that it affects his eyesight.

```
            'OK'

32 P:    °ừ°
  Huy     mm

            'Mm'

33        (3.0) ((The doctor is probably looking at the X-ray result))

34 P:    trước+đây  a  (.)  trước+đây  họ   nói  anh          bị
  Huy     past        PRT    past       they  say  older+brother  have

35       viêm+đa+khớp+dạng+thấp
         rheumatoid+arthritis

            'In the past, the doctors said I had rheumatoid arthritis'

36        (2.1)

37 P:    nhưng+mà  đợt    ni   #hình#+như: (0.2)
  Huy     but       period  now  seem

38       <#hắn#  thoái+hóa  cột+sống  cổ        với   lưng>
         it      degenerate  spine     cervical  with  lumbar

            'but now it seems that I'm suffering from cervical and lumbar
            spinal degeneration'

39        (13.1) ((The doctor is probably looking at the X-ray result))

40 D:    cột+sống  cổ       anh            ri         đau  là
  Si      spine     cervical  older+brother  like+this  pain  COP

41       đúng       rồi
         definitely  PRT

            'A cervical spine like yours will definitely cause pain'

42        (0.4)

43 P:    mà- mà- mà  anh            tập       rất  là  ĐIỀU    (0.6)
  Huy            but  older+brother  exercise  very  COP  regularly

            'But I exercise very regularly,'

44 P:    sâu          =nhưng+mà  khi+mà  anh            tập       mà  cí
  Huy     strenuously  but        when    older+brother  exercise  with  CLA

45       cường+độ   mà  #hắ:n# (.)  hơi       lớn   một  cái  a  (.)  là
         intensity  COP  it          slightly  hard  a    bit  PRT      COP

46       #hắn#  sưng
         it     swell

            'strenuously, but my spine swells up when I take exercise hard'

47        (0.5)

48 P:    bò  mấy  ngày  ni     anh            có     lấ::y  muối  sống
  Huy     so  PL   day   these  older+brother  PERF   use    salt  raw

49       với   hành  đồ    rứa   anh            chườm  cho      #hắn#
         with  onion  thing  like  older+brother  use    so+that  it

50       đỡ       nhức  a
         reduce   pain  PRT

            'So these days I use raw salt and onions or something like that to
            reduce the pain'

51        (1.2)

52 D:    #hắn#  ľlan  (.)  xuống  hai  tay  nhiều  không?
  Si      it     affect     down   two  arm  much   INT
```

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'Does the pain affect both arms much?'

53   (0.5)

54 P: à:: (0.4) TAY ni-   thì- bị-   >TAY ni<
  Huy   uh   arm this COP   affect arm   this

        'This arm's affected, this one'

55   (0.7)

56 D: tay phải   #phải+không#?=
  Si   arm right   INT

        'Your right arm's affected, isn't it?'

57 P: =là: (.) cái ↑vai   phải
  Huy   COP   CLA shoulder right

        'The pain's in my right shoulder,'

58   (1.8)

59 P: mà tuần mười ngày ni   tập   điều   lại   a   =thì
  Huy   and week ten day these exercise regular again PRT then

60   hai tay #hắn# >hoãn+lại rồi<
         two arm they stop   PERF

        'and my arms have stopped hurting thanks to regular exercise again
        over the last week to ten days'

61   (0.5)

62 P: mà có   cái là: mấy kí- kí- kí- kí (0.7)
  Huy   but have PRT COP PL   CLA

63   hình+như thời+tiết #hắn# đổi   hay răng mà cứ:
         probably weather   it   change or how COP CLA

64   =mấy cái khớp a (.) #hắn# nhức (0.3) cái lung+quần
         PL   CLA joint PRT   they ache   CLA waist

65   rất là đau   (.) cái thắt+lung a+nã (0.5) với cái cổ
         very COP painful   CLA waist   PRT   with CLA neck

        'But probably due to the change in the weather, my joints have
        been aching and my waist has been very painful, and so has my
        neck'

        The problem presentation stage begins with doctor Si's general inquiry
question to seek Huy's major concern (line 4). Huy responds with a *multi-unit telling
preface* (Robinson & Heritage, 2005) in lines 6-7 that includes a *simple-past-tense
event* (Labov & Waletzky, 1997), *hai lần hè* ('the last two summers; line 7), to
foreshadow a narrative. He produces the medical history through the temporal
reference *hai lần hè* ('the last two summers'; line 7) in order to increase the severity
of the first problem presented at line 17. From his medical history, Huy establishes
the reason for today's visit (lines 14-15). The adverbial intensifier *quá* ('so' in the
gloss; line 14) and the word *lại* ('again'; line 15) mark a description of his condition
as recurrent and raise questions of its doctorability. However, it is not until after this

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information is articulated that he officially answers Si's general inquiry question at line 4. Huy prefaces his answer with *cái đau thứ nhất* ('my first problem'; line 17) to alert Si that at least a second concern will be forthcoming, and that at least one further TCU will be required to talk about it. Huy names the first illness, *VAI GÁY* ('upper shoulder'; line 17); then, after receiving a *go-ahead* (Schegloff, 2007) from Si, he projects a short course-of-action narrative about his upper shoulder based on an example from his work (lines 20-22). Faced with no uptake from Si after a 0.6-second silence (line 23), Huy adopts another story preface at line 24 to proceed with the second problem and its past treatment (lines 25-27).

The consultation is paused for 3.0 seconds (line 33), during which time doctor Si is presumably reading the X-ray result. Huy then explains the X-ray result by stating a past diagnosis, *viêm đa khớp dạng thấp* ('rheumatoid arthritis'; line 35), delivered by invoking the third party, *họ* ('the doctors'; line 34), consisting of other health experts who performed the X-ray test. Without any feedback from Si, Huy, in a downgrading fashion expressed by *hình như* ('[it] seems [that]'; line 37), states the current diagnosis, *thoái hóa cột sống cổ với lưng* ('cervical and lumbar spinal degeneration'; line 38), based on his lay knowledge through reading the test result. By downgrading his claim, Huy looks for Si's expertise to confirm his assumption. Si makes a comment on Huy's cervical spine (lines 40-41) that is topically conforming to Huy's prior turn (lines 37-38) but does not overtly assess Huy's diagnostic assumption. Nevertheless, it can be inferred from his comment that Si agrees with Huy that his upper shoulder is in a serious condition. Next, Huy reports how he has attempted to treat this problem (lines 43-44), its consequences for his intense exercise regime (lines 44-46), and the herbal medicine he takes as a first-aid therapy (lines 48-50). Si's silences (lines 43 and 47) display his orientation to Huy's talk as *a story in progress* (Halkowski, 2006). Si gives no assessment after 1.2 seconds (line 51), but moves on to the next agenda item: the pain in Huy's arm (lines 52-60). Huy describes the right arm problem (lines 54 and 57) and reports the effectiveness of his exercise on the recovery of his arm (lines 59-60). Huy wraps up his presentation with a repeat of the waist pain (lines 62-65) plus a tentative cause, *hình như thời tiết hắn đổi* ('probably due to the change in the weather'; line 63), based on his own experience. After a 0.5-second pause (line 65), he repeats the first concern, *với cái cổ* ('and so has my neck'; line 65), to remind Si of its doctor-relevance (Halkowski, 2006). The whole turn in lines 62-65 aims to finalise the two

main concerns: upper shoulder and waist.

In his presenting problems, patient Huy develops a chronologically organised description that: (i) provides the temporal context of his illnesses (lines 6-7 and 14-15), (ii) names the illnesses (lines 17 and 25-26), (iii) lists their symptoms (lines 20-22 and 25), (iv) establishes the reason for his visit (lines 14-15), (v) reports past diagnoses and treatment (lines 6-7, 34-35, and 37-38), (vi) discloses details of his own temporary treatment (lines 43, 44-46, 48-50, and 59-60), and (vii) states the cause (lines 62-65). It can be seen from this extract that Huy continues his narrative (lines 62-65) despite Si's topic shift (lines 52-60). Huy's overall structural organisation carries several implications. Firstly, his description of the pain severity with some examples conveys the reasonableness of bringing his problems to the doctor. Secondly, Huy's exercise and his initial efforts to treat the problems highlight the fact that he has tried to be a good patient and get better by himself. Thirdly, his diagnoses, exercise, and use of herbal medicine exhibit his lay knowledge of the problem. Fourthly, the long medical history of the problem (the last two summers) indicates the persistence of the problems, which means he has been experiencing and dealing with various levels of pain for a long period of time. Lastly, his report of two previous courses of treatment in this hospital together with his return to this hospital for today's visit displays his orientation to receiving the same treatment method again. In short, by constructing his presentation as a narrative sequence, Huy not only presents his main concerns but also discloses information that may have some bearing on Si's treatment recommendation later.

5.2.7 Presentation without being elicited

Discovering the patient's major reason for seeking care is a critical step in determining further treatment, as observed in both CA and non-CA studies (e.g., Beckman & Frankel, 1984; Dyche & Swiderski, 2005; Heritage & Robinson, 2006b). Nevertheless, some follow-up visits in the data pass by without any doctor elicitation because they are pre-empted by the patient. The sequence of this pre-emptive presentation occurs right after the doctor asks the patient to settle themselves for the consultations. Their presentations commence after a silence during which doctors are probably waiting for patients to climb onto the bed and get ready for the consultation. Since most of the consultations in the data begin with doctor elicitation, this patient pre-emption is considered a deviant case. This pre-

emption practice is illustrated in Extract 5.15 between doctor Hai and outpatient Ban, who comes to the hospital on a daily basis for acupuncture. Ban had arthritis in her shoulder, back, and leg, but her back has recovered 50% thanks to previous treatment. This extract is concerned with her shoulder. In lines 7 and 10, Ban pre-emptively presents her problem without waiting for Hai's elicitation.

```
Ex. 5.15: B 9 & 59

1   D:    rồ:::i (.)  dì    Ban
    Hai   so          aunt  Ban

          'So, Ban'

2   P:    rồ:i
    Ban   yes

          'Yes'

3         (0.8)

4   D:    dì    ngồ:::i (0.3)  dựa  vô đây   xem¿
    Hai   aunt  sit            lean on here  PRT

          'Please lean back on this bedhead'

5   P:    #rồi#
    Ban   OK

          'OK'

6         (1.0)

7   P:    chừ::#h- hắn# đau     xuống đầu+gú:i luôn Hai ơi¿
    Ban   now          it  painful down elbow     also Hai INTJ

          'Now, it's also²² painful down to my elbow, Hai'

8         (0.4)

9   D:    [dạ rồ::i   ]
    Hai   HON OK

          'OK'

10  P:    [đâ::y- đầu ]+gú::i  (đỏ) này- (.) đầu khuỷ:u+tay ni   này
    Ban   look    elbow        red  here     CLA elbow     this here

          'Look! My elbow's red. This elbow'

11        (1.3)

12  D:    đa:u răng?=
    Hai   pain how

          'How's the pain?'

13  P:    =trên ni:=
    Ban   up    here

          'Here'

14  D:    [=giờ+chừ]
    Hai   now
```

---

²² The patient means the pain in her shoulder (previous concern) has not gone, but spread to her elbow (current concern) as well.

```
           'Now'

15  P:    [cái ni  ]
   Ban    from this

16  D:    tọa  trên [xuống    luôn à:? ]
   Hai    pain top  downwards also INT

          'It runs downwards now?'

17  P:              [xuống   đây        ]
   Ban              down     here

          Lines 15 & 17: 'From this part down here'

18  P:    xuống   đây
   Ban    down    here

          'down here'
```

In lines 1 and 4, doctor Hai requests that Ban settle down for the consultation. Hai says nothing after a 1.0-second silence (line 6), probably because he is waiting for Ban's readiness, when Ban initiates her recovery assessment (line 7). She uses the word *luôn* ('also'; line 7) to indicate the addition of elbow problem to a previous concern (i.e., shoulder), thus marking this visit as a follow-up. By showing Hai her red elbow (line 10), Ban justifies her previous claim made at line 7. Hai delays his response for 1.3 seconds (line 11) before projecting two history-taking questions in lines 12, 14, and 16. His first question can be seen as approaching a point of completion at *răng* ('how'; line 12) when Ban times the onset of her talk to add the pain location, =*trên ni:=* ('here'; line 13). However, Hai immediately produces a second question (lines 14 and 16), which in turn results in twice overlapping with Ban's talk in lines 15 and 17. Ban closes the sequence with a repeat of the information about the painful area to resolve any mishearing that the overlapping talk may cause to Hai (line 18).

It can be seen from Extract 5.15 that patient Ban pre-emptively describes her concern (lines 7 and 10) without waiting for Hai's elicitation. The first information (line 7) is about a new symptom relating to her previous concern (i.e., shoulder) while the second aims to justify her claim (line 10). After her first turn (line 7), Ban does not wait for Hai's turn but continues to disclose the symptom (line 10), which causes overlapping talk (lines 9 and 10). Note that, as the conversation goes on, several instances of overlapping talk occur (lines 14-15 and 16-17). In addition, Ban presents her concern in a quick manner (symbolised by '=' at line 13). Overall, her interactional organisation of pre-emption can be explained in three ways. First, her pain has become more and more severe since the last visit so she wants to inform Hai

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promptly. Second, her pre-emption may be determined by her relationship with this doctor. Specifically, she addresses him with his plain given name *Hai* (line 7), which is only common in intimate relationships among speakers of the same age, family members, or close friends (Cooke, 1968; H. T. Nguyễn, 2006). Her use of this address term leads one to believe that she has met this doctor at least once before (either for the same or a different concern) and their relationship is close enough to use such a term, given the hierarchical society of Vietnam. Third, this pre-emption may be due to her turn-taking style, which accounts for her active involvement in the consultation. To recap, the absence of elicitation does not mean that Hai skips this step. Rather, he is pre-empted by Ban.

5.3 Chapter conclusion

We have seen that the participants in the current study used different formats for elicitation and disclosure of the major concerns. The doctors orient to the existence of three different types of visits (i.e., first visit, SDF, and DDF). From this emerged two prominent reasons for the patients' visits: dealing with new concerns (for first visits) and follow-up concerns (for SDFs and DDFs). Departing from this orientation, the doctors design their elicitors in accordance with the patients' types of concern. However, their elicitation design is largely shaped by their epistemic stance towards the patient's concerns, which in turn is mostly determined by medical records or referral letters. In the event that there are no medical records or referal letters, doctor elicitors tend to be inappropriate to the visit types, and this mostly happens in SDFs to the consulting rooms, and DDFs. In contrast, due to some prior knowledge gained from medical records or referral letters, some doctors in first visits to the ward also use inappropriate elicitors that convey their strong epistemics about the patient's concerns. Only first visits to the consulting room and SDFs to the ward have appropriate elicitors. These elicitors are institutionally relevant, as doctors in first visits to the consulting room have no medical records or referral letters to consult beforehand, whereas those in SDFs to the ward are able to fully grasp the patient's concerns thanks to information from previous visits.

In response to the doctor elicitors, the patient deploys one or more types of presentation to describe their problems. Their presentation practices also convey a need to raise the issue of doctorability so as to justify their decisions on seeking medical care (Heritage & Robinson, 2006a). Notably, apart from presenting their

concern(s), patients also volunteer self-diagnoses, assessments, causes, or reasons for choosing this hospital, and this information is not elicited by doctors. Overall, the patients have a range of choices concerning both the content and the deployment of the concern presentations, which may align with or resist the doctors' agendas. It is this presentation that shapes the trajectory of the consultation.

Chapter 6

History-taking and physical examination

6.0 Introduction

Chapter 6 touches upon the information-seeking activities during history-taking and physical examination. The pieces of information to be sought during history-taking and physical examination in first and follow-up visits are similar; however, in the latter, doctors also elicit the patient's update of their health condition since the last visit. Because of this, I have not separated the activities of the first visits from those of the follow-up visits in the remaining analytic chapters. As the order of the information being sought (e.g., symptom, cause, or recovery assessment) varies across visits, the order in which this information is presented in these chapters does not always reflect the actual order in which it occurs in medical consultations. For instance, some doctors elicit the duration of the problem prior to its symptoms while others take an opposite approach.

Once patients have presented their major concern, doctors focus the consultation towards eliciting specific types of information that can assist in identifying possible diagnoses. In a set of communication guideline for nurses, Cox, Turner, and Blackwood (2004) assert that information about the history of a current concern enables doctors to identify: (i) what has happened, (ii) the patient's personality, (iii) how the patient's concern has affected the patient and their family, (iv) any of their anxieties, and (v) their physical and social environment. It establishes the doctor-patient relationship and informs the diagnosis. This information can be grouped under two broad categories: information related to the current problem and information about the patient's medical history. The first category includes recovery assessment (Section 6.1), symptoms (Section 6.2), causes of the problem (Section 6.3) and duration of the problem (Section 6.4), and the second past diagnoses and treatments (Section 6.5), lifestyle issues (Section 6.6) and past problems (Section 6.7).

6.1 Recovery assessment

As discussed previously, doctors undertaking a follow-up visit often elicit an update on the patient's concern since their last visit. Doctors in some first visits also elicit a

recovery assessment, and this occurs when patients have already undergone treatment for the same concern at another health institution. In this case, they ask patients to evaluate their health recovery. This updates doctors on the nature and severity of the health problem and allows an assessment regarding the efficacy of previous treatments that can be used in the current consultation treatment plan. Additionally, while in SDFs recovery assessment takes place at the beginning of the consultations, or is integrated into the problem presentation sequence (e.g., Extracts 5.3 and 5.5), this activity tends to appear later in first visits and DDFs.

Moreover, within the general category of recovery assessment, follow-up and first visits are associated with different subtypes of assessment. In follow-up visits, doctors tend to use detailed assessments. This involves asking patients to quantify (as a percentage) how much they have recovered, or evaluate their health status at a specific point in time.[23] Detailed assessments are preferred in follow-up visits because they update doctors on the effectiveness of previous treatment plans formulated by this hospital. Via this update, doctors can decide whether the same treatment should be prescribed or a change is needed. In first visits, by contrast, there is a preference for general assessments. That is, the doctor only wishes to know whether the problem has decreased in severity or not. Therefore, it is institutionally relevant for doctors to elicit this type of assessment in a first visit, as this enables the doctor to obtain a brief overview of the pain progress since the patient's previous treatment at another health institution.

Eliciting detailed assessments is illustrated in Extract 6.1 between doctor Nguyet and patient Tran. Tran has had pain in her back running down her leg, which seriously affects her movement. She was discharged from this hospital two days ago and has now returned for another course of treatment. This extract is taken right after Tran presents her major concern. In this DDF consultation, Nguyet deploys information-seeking activities by continuously reconstructing her turns to gain deeper insight into the pain development (all arrowed).

Ex. 6.1: B 11 & 66
```
26 D:→     à::: (.) rồi  xong rồi  đi   vô+điều+trị nằm  đây  một ĐỢT
Nguyet     uh       then PRT  then come treatment   stay here one course

27         thì (.) thấy cũng #không# đỡ     lắm à?
           COP     feel PRT   not     better any INT
```

_____

[23] Most of the participating doctors in this study used percentages as a scale for assessing recovery.

```
              'But you don't feel any better after one course of treatment
              here?'

28            (.)

29 D:         hay răng?
Nguyet        or   what

              'If not, what, then?'²⁴

30 P:         dạ   KHÔ:NG (0.3) có:   [về]
Tran          HON  no             yes  home

              'Yes. At home-'

31 D:                            [có]  đ[õ::]
Nguyet                           PERF  better

              'You feel better'

32 P:                                    [có ] đi   được chơ,
Tran                                     PST  walk able PRT

              'I was able to walk around'

33            (0.2)

34 D:         à::
Nguyet        oh

              'Oh'

35 P:         về    em              lết  lết  lết  em              đi   luôn đó,
Tran          home  younger+sister drag drag drag younger+sister walk soon PRT

              'As soon as I got home, I tried to walk with my leg dragging
              along behind me'

36 D:→        ừ:  mà  xong về:::  cõ+khoảng #một# tuần bờ   về   đau  lại=
Nguyet        OK  but then home  about      one   week then home pain back

              'OK, but the pain came back after about one week at home'

37 P:         =dạ  KHÔNG=
Tran          HON  no

              'No'

38 D:         =hay răng?=
Nguyet        or   what

              'If not, what, then?'

39 P:         =em              mới::(0.5) mới  về: (.)
Tran          younger+sister              just home

40            >ra        viện     khi ngày thứ ha:i  a¿<
              discharge  hospital on  day  CLA Monday PRT

              'I was discharged from the hospital just on Monday'
              ((It is Wednesday today))

41 D:         à::
Nguyet        oh

              'Oh'

42 P:         nên+là  hắn (0.2) nói+chung là  chừ hắn
Tran          so      it        basically COP now it
```

---

²⁴ The translation 'if not, what, then?' is the closest that I could come to an idiomatic translation. It gives a somewhat brusque impression which is not present in the original Vietnamese.

```
43          còn    đau    (0.4)  với   tê
            still  painful       with  numb

            'so, basically, this area's still painful and numb now'

            ((32 lines deleted - Verbal and physical examination))

75 D:→      °à::° (0.2) nhưng  khi  chị::::      (.)  mới  ra     viện
Nguyet      uh          but    when older+sister      just leave  hospital

76          ngày thứ hai   là   có  đau   kiểu  như   ri    không?
            day  CLA Monday COP  PRT pain  feeling like  this  INT

            'But did you have this pain when you left the hospital on
            Monday?'

77          (0.4)

78 P:       nói+chung hắn #cũng# cò::n¿
Tran        basically it   also  still

            'It still hurts, basically'

79 D:       vẫn+còn  đau¿
Nguyet      still    hurt

            'It still hurts'

80 P:       cò:n    [chơ  ]
Tran        still   PRT

            'Sure'

81 D:              [nhưng ]+mà  chừ cảm+giác đi   khó:  hơ:n phải+không?
Nguyet             but         now feeling  walk hard  more INT

            'But walking's harder now, isn't it?'

82 P:       dạ  ʰkhông (.)  hắn cũng rú::a thôi
Tran        HON no           it  PRT  same just

            'No. It's just the same'
```

Doctor Nguyet's first question addresses Tran's recovery after one course of treatment (lines 26-27 and 29). It is initiated in the form of an assessment with the negative marker, *#không#* ('not'; line 27), which maximises the chance of obtaining a 'no' answer. By formulating an assessment that presupposes no recovery, Nguyet adheres to the principle of problem attentiveness, given that Tran has returned for a follow-up visit after just two days. Nevertheless, after a micro pause (line 28), Nguyet uses the "monitor space" (Davidson, 1984, p. 104), *hay răng?* ('if not, what, then?'; line 29), to offer multiple options for responses (Bickley & Szilagyi, 2013). Monitor space refers to the addition of a redundant component to the end of the turn to anticipate rejection (Davidson, 1984). Of note is the contrast between two options for responding to this alternative-question turn: a 'yes/no' question (lines 26-27) and a wh-question (line 29). In doing this, Nguyet, on the one hand, displays some of her prior knowledge of Tran's concern through her observation of Tran's pain, *rồi xong*

rồi đi vô điều trị nằm đây một đợt thì thấy cũng không đỡ lắm à ('but you don't feel any better after one course of treatment here?'). On the other, she leaves room for Tran's own description (*hay răng?* 'if not, what, then?'). Although Nguyet's presupposition is rejected (lines 30, 32, and 35) and Nguyet has grasped this rejection (lines 31 and 34), she elicits another assessment with the same two-option format (lines 36 and 38) and same presupposition of no recovery. Tran provides two responses immediately (lines 37 and 39-40), which are termed as a *latched-to-possible-completion onset* (Jefferson, 1984). A latched-to-possible-completion onset means the current turn is perfectly juxtaposed with the prior turn. However, none of these responses answer Nguyet's elicitation. Rather, they reject her presupposition (i.e., *về cỡ khoảng một tuần* 'after about one week at home'; line 36), which receives Nguyet's news marker *à::* ('oh'; line 41). This news marker means that Nguyet did not monitor Tran's hospitalisation on her last visit, and thus this is a DDF. From Tran's existing symptoms, *đau với tê* ('painful and numb'; line 43), Nguyet takes a verbal and physical examination (lines 44-74; data not shown). Once the pain is physically located, Nguyet elicits one more assessment using *a compound TCU* (Lerner, 2006), *nhưng…là* ('but…when'; lines 75-76). This elicitation also focuses on the pain severity when Tran left the hospital. In reply, Tran provides a general answer prefaced with *nói chung* ('basically'; line 78) to announce a general assessment. Nguyet then projects a tag question conveying her presupposition regarding the difficulties Tran may have with her walking (line 81).

Notice the way doctor Nguyet frames three questions looking for an assessment of Tran's recovery (all arrowed). In one form or another, they all embody the presupposition that Tran has not recovered from her problem. Note also that Nguyet's questioning approach is contextually appropriate in terms of their content and their overall sequence structure, in that her three questions aim to obtain a detailed update of the development of Tran's pain and her recovery across periods of time. Particularly, Nguyet anchors the pain status to various temporal references: the last period of hospitalisation (lines 26-27 and 29), the period at home (lines 36 and 38), and the date of discharge from the hospital (lines 75-76). These references are logically connected to the interactional actions of their questions. The first question (lines 26-27 and 29) receives a dispreferred answer that only generalises the pain status (lines 30-32). In the face of the implication that the pain has reduced during the hospitalisation, Nguyet tries to find the reason for the visit with another question

relating to the pain recurrence when Tran is at home (lines 36 and 38). Yet, the answer to this second question is still general (lines 39-40 and 42-43) and seemingly contrasts with the previous one, which states that the pain has decreased (lines 30, 32, and 35). At this juncture, it seems that Nguyet has not yet obtained a satisfactory answer. Therefore, after grasping the severity of the pain through examination, she projects one more question (lines 75-76) to evaluate the progress of the treatment since the date of discharge.

In response to the doctor elicitors intended to assess the patient's recovery, patients also demonstrate their lay knowledge of the problem, interpolate information about other symptoms, establish the reasons for the visit, complain about a failure to recover, or acknowledge the value of previous treatment. These types of information are disclosed later in the recovery assessment sequence without being elicited. In disclosing these types of information, patients establish their reason for the current visit in the first visits, but shed light on the doctor's past treatment in the follow-up ones. For example, in the extract below, patient Ban expands the assessment sequence to complain to doctor Hai about the fact that her arm still hurts (arrowed). Ban has arthritis in her arm, back, and leg, but her back has recovered 50% due to previous treatment at this hospital. This consultation thus only deals with her arm and leg (data not shown).

Ex. 6.2: B 9 & 59

```
76  D:    răng? (.)   đợt      trước  là::::::::: (0.2) điều+trị   Đỡ+được
   Hai    so          course   last   COP                treatment  better

77         mấy   phần   rồ:i?
           how   percent PRT
           'So, how much better is it since the last course of treatment?'

78         (0.6)

79  D:    nói   #cái#  LƯNG  a
   Hai    mean  CLA    back  PRT
           'I mean your back'

80  P:    #cái#  lu:ng  là   cỡ     năm+mươi
   Ban    CLA    back   COP  about  fifty
           'My back's back to about fifty percent'

81         (0.2)

82  D:    năm+mươi  ha:?
   Hai    fifty     INT
           'Fifty?'

83         (0.9)
```

143

```
84  D:    lu:ng thì giừ:: là::- là:::
   Hai    back  COP  now         COP

          'Now your back's-'

85  P:→   cò:n ta:y thì đau  =hắn #không# bót   nơi,
   Ban    but  arm  COP hurt it   no     better PRT

          'But my arm still hurts. It's no better'

86  D:    ta:y hắn #không# bót?
   Hai    arm  it   no     better

          'Your arm is no better?'

87        (0.4)

88  P:    °dạ:°
   Ban    yes

          'No'
```

Doctor Hai initiates the topic agenda of assessment with a focus on Ban's back pain (lines 76-77 and 79). He employs the temporal marker *đợt trước* ('the last course of treatment') to register that this is a follow-up visit, and to link the assessment with the previous visit. The word *ĐỠ* ('better') presupposes a positive outcome: in doing this, Hai aligns with the principle of optimisation – "a fundamental 'default' principle of medical questioning" (Heritage & Clayman, 2010, p. 144). His interrogative marker, *mấy phần* ('how much?'; line 77), makes relevant Ban's assessment on a percentage scale, *năm mươi* ('fifty percent'; line 80), which is marked as approximate, *cỡ năm mươi* ('about fifty percent'; line 80). Hai receives her assessment with a partial repeated declarative question, *năm mươi ha?* ('fifty?'; line 82), to obtain her confirmation of the figure. After a pause of 0.9 seconds (line 83), Hai makes an assessment of Ban's back, but then cuts himself off at the copula *là:::* (line 84). At this juncture, Ban transitions to the topic of her arm, which is no better (line 85). She prefaces this two-TCU turn with the word *còn* ('but') to foreshadow a contrastive matter. Right after the first TCU, *cò:n ta:y thì đau* ('but my arm still hurts'; line 85), Ban rushes through the TRP (symbolised by '=') to elaborate on the pain quality, *hắn #không# bót nơi* ('it's no better'; line 85). She replaces the words *thì đau* ('[my arm] still hurts') with *không bót* ('no better'), for fear that *thì đau* ('[my arm] still hurts') can mean minor pain rather than non-recovery, and emphasises *đau* ('[my arm] hurts') and *bót* ('better'), to alert that the pain remains unchanged. The turn has an upward-intoned ending, *nơi,* (i.e., marked by a comma), that is considered a questioning act rather than an informing act. All of

the linguistic deployments above display an orientation to the fact that the previous treatment for her arm was ineffective.

Extracts 6.1 and 6.2 have illustrated how doctors design different questions to elicit a recovery update, and how patients formulate their responses so as to update doctors about their pain status. Doctor elicitors are locally and indexically shaped by the visit type and by their prior knowledge of the patient's problem. In turn, these elicitors set topical and action agendas that embody certain presuppositions, following the principles of problem attentiveness and optimisation. In particular, if the patient has returned for a follow-up visit, the doctor might presuppose the existence of a problem that the patient has not recovered from, while other doctors assume that the patient has recovered at least to some extent after a course of treatment. In responding, patients not only provide the requested information but also expand their talk to volunteer more information. In terms of its content, their expansion sequence raises the doctorability for today's visit and challenges the doctor's treatment plan.

6.2 Symptoms

In their manual for medical providers, McDaniel, Campbell, and Seaburn (1990) claim that eliciting symptoms enables doctors to "speak the patients' language, enter their belief system, and metaphorically gain access to and validate their emotional experience" (p. 253). Previously, I showed that some of the doctors' problem presentation questions aim to elicit symptoms (e.g., Extracts 5.1 and 5.2). The symptom elicitation sequence can also resurface at later moments during the consultation. In eliciting symptoms, the participating doctors adopt two methods: opening (general) elicitation and detailed elicitation. Opening elicitation refers to the use of general questions in wh-formats that aim to elicit an in-their-own-words description. Detailed elicitation closely focuses on a specific symptom, and often has the format of a polar question. In response, patients describe symptoms, then sometimes expand their response to increase the perceived severity of the problem, name the problem, disclose information about self-treatment, or make an assessment of the problem.

Doctor's general elicitation is illustrated in Extract 6.3 between doctor Quynh and patient Vuong. Vuong received one course of treatment at the current hospital for his backache, and now he would like to seek treatment for another concern:

haemorrhoids. At the beginning of this consultation, Quynh supposes that Vuong has come back for a follow-up related to his backache. However, it is not until Vuong discloses that he has haemorrhoids that Quynh steers the consultation towards this concern. Right after Vuong presents his concern of haemorrhoids (data not shown), Quynh asks him to describe their symptoms (line 58).

```
Ex. 6.3: B 1 & 6
58 D:→   chừ triệu+chúng /ra+răng hè?
Quynh    now symptom    what    INT

         'What are the symptoms of your haemorrhoids?'

59       (0.3)

60 P:    triệu+chứ:::ng thì coi+như hắ:::::n à::::::::::::::: (0.9)
Vuong    symptom      COP seem    they    uh

61       #đó# là  nhiều+khi   là  hắ:::::::n à::::::: (.) hắn bị:::
         that COP occasionally COP they    uh          they suffer

62       à::::::::::::::: (0.3) >tự+nhiên      #hắn# ĐAU<
         uh                    for+some+reason they  hurt

         'The symptom seems to be that they hurt occasionally for some
         reason'

63       (0.7)

64 D:    [dạ:]
Quynh    OK

         'OK'

65 P:    [hắn]đau    mà  hắ:::n à::::::::::::: (0.2) #hắn# NGỨ::A
Vuong    they painful and they  uh                  they  itchy

         'They're painful, and they're itchy'

66       (.)

67 P:    >cả  đau  cả  ngứa  rứa<
Vuong    both hurt both itchy like+that

         'They're both painful and itchy'
```

To elicit patient Vuong's symptoms of haemorrhoids, Quynh asks a general question employing a 'what' marker and the medical term *triệu chứng* ('symptoms'; line 58). After a 0.3-second silence (line 59), Vuong responds by mobilising various discursive resources like repeating some aspects of Quynh's preceding turn, *triệu chứng* ('symptom'; line 60); stretching talk, *chứ:::ng* ('symptom'; line 60), *hắ:::::n à:::::::::::::::* ('they'; line 60), *hắ:::::::n à:::::::* ('they'; line 61), *bị::: à:::::::::::::::* ('suffer' in the gloss; lines 61-62); using three *hesitation markers*[25] (Gardner, 2001) *à* ('uh' in the gloss; lines 60-62); and pausing three times (0.9

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[25] A hesitation marker indicates the use of a focal phenomenon as a turn-holding device.

seconds, a micro pause, and 0.3 seconds; lines 60-62). All of these resources mark the symptoms as difficult to name or characterise. Despite these difficulties, Vuong is able to get his answer across because Quynh's *dạ* ('OK'; line 64) uptake, produced in initial overlap with Vuong's turn at line 65, signals her understanding of Vuong's description. Quynh's *dạ* ('OK') is treated as a go-ahead that encourages Vuong to continue his talk. Vuong then elaborates on his claim by repeating the mentioned symptom, *đau* ('painful'; line 65), and appending another symptom: *NGỨ::A* ('itchy'; line 65). He ends the sequence with a summary of these two symptoms (line 67).

Notice how doctor Quynh formulates her question in pursuit of the information about Vuong's symptoms (line 58). She does not format her turn in the way that some doctors commonly do, and she herself often does with other patients, by asking 'how's the pain?' (e.g., Extract 5.15). Instead, she overtly asks Vuong to describe the symptoms using the medical term *triệu chứng* ('symptoms'), which might be too technical for Vuong to understand.[26] In addition, Quynh employs a non-alternative question prefaced by *răng* ('what') to communicate that the information she is trying to elicit is general rather than specific. Quynh's design of this general question reflects her assumption that this consultation is a follow-up visit related to Vuong's backache, not a first visit concerned with his haemorrhoids (data not shown). Probably due to the sudden change in the trajectory of the consultation, Quynh has little access to information about Vuong's new concern. Her general elicitation institutionally licences Vuong to describe his experience in his own terms; thus, Quynh is able to grasp the symptoms thoroughly. We see that Vuong provides an extensive depiction of his current symptoms in an unrestricted manner, hence creating a comprehensive picture of the problem. Though it has a circuitous route, Vuong's uptake (lines 60-62, 65, and 67) treats Quynh's terminology, *triệu chứng* ('symptoms'; line 58), as understandable.

While doctor Quynh uses a general question to elicit symptoms, doctor Lam in Extract 6.4 uses examples to trigger patient disclosure of symptoms. This practice is often located in the middle of the sequence that elicits syptoms. In this practice, doctors cite an example to illustrate how patients' physical activities are hampered

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[26] In Vietnamese, *triệu chứng* ('symptoms') can be considered a medical term, especially in interactions with the patients with lower socio-economic status. Instead, Vietnamese doctors often use a more common word, *dấu hiệu* ('signal'), or a common question, *Đau như thế nào?* ('What's the pain like?' or 'How's the pain?').

by their health problem(s), and then invite patients to (dis)confirm their claims (see Extract 6.4). Syntactically, the example practice does not have the form of a question that demands an answer; however, it can evoke a response through doctor interactional and linguistic organisation (e.g., prosody, word choice). Extract 6.4 is Lam's first visit with inpatient Thu, who has pain in her kneecaps. On receipt of Thu's main concern, Lam uses two examples (arrowed) to illustrate the symptoms and elicit Thu's confirmation.

```
Ex. 6.4: B 3 & 53

6   D:    ˈrăng  mệ     Thu ˈhè:::?
    Lam   how    grandma Thu PRT

          'How can I help you, Thu?'

7         (1.5)

8   D:    đa:u   ˈrăng  mệ     [hè::?]
    Lam   trouble what   grandma PRT

          'What seems to be the trouble?'

9   P:                            [đa:u] (0.2) đau    cái chân ˈghê::::
    Thu                                        painful CLA leg   very

10        mà- [mà-  ]
              and

          'My legs are very painful and'

11  D:        [dạ:::]::::::(.) ui+ˈchà  khớp+gố:i  nữa  ha::?
    Lam       OK               goodness kneecap    also INT

          'OK. Goodness, you also suffer from a kneecap problem?'

12        (0.2)

13  P:    gối    mà::-(.) mà::::::  (0.5)  mà  có  chụp+phim
    Thu   kneecap                          and PST X-ray

14        dưới ông Dũng a   =họ   nói     GA::I
          at   Dr  Dung PRT  they describe prickling

          'Yes, and I had my kneecaps X-rayed at Dr Dung's clinic and they
          were described as prickling'

15  D:    dạ: ˈga:::::i  (.)  đúng+rồ::i
    Lam   yes prickling       right

          'Yes, they're prickling. Right'

16        (0.4)

17  D:    bây+giờ:: con      hoải nghe:¿
    Lam   now       offspring ask  PRT

          'Now, let me ask you'

18        (0.3)

19  P:    °ˈờ:°
    Thu   yeah

          'Yeah'
```

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```
20  D:→  là- (0.2)  mệ:-   (0.3)  đi:::  a: (0.4)  nhút+là
    Lam  COP         grandma        walk   PRT        especially
21       ngồi xuống đứng  dậy #không# nổi mô    [nã  ]
         sit  down  stand up  not      can at+all PRT
         'Your walking- you especially can't sit down or stand up'

22  P:                                          [không ] được
    Thu                                          not     can
23       =#không# đượ:c
         not      can
         'No, I can't'

24  D:→  đi   xuố:ng cầu+thang cũng đau  lắm   a   nã
    Lam  walk down   stairs     also hurt a+lot PRT PRT
         'Your kneecaps also hurt a lot when you go down a flight of
         stairs'

25  P:   bướ:c- (.) bước lên là:::(0.4) thôi     quy:::
    Thu             go   up  COP        impossible exhausting
         'Going up some stairs²⁷ is impossible, it's exhausting'
```

In this extract, eliciting symptoms is made as an initiation of the problem presentation (lines 6 and 8). The first question (line 6) is non-specific while the second is a little more specific through the addition of the word *đa:u* ('trouble'; line 8). The second question, which uses the interrogative marker *↑răng* ('what'), is general, and encourages patient Thu to answer in her own words with little constraint on the action agenda of Thu's response. This question makes her answer relevant to the pain location plus its intensity (line 9). Thu intends to disclose further information after the conjunction *mà- mà-* ('and'; line 10), but is interrupted by Lam's uptake, *dạ* ('OK'; line 11) and his diagnosis, *khớp gố:i* ('kneecap problem'; line 11). At this juncture, Thu partially repeats Lam's diagnosis to assert her primary right from second position (Stivers, 2005a), then does a *resumption search* (Schegloff, 2007) to report the diagnosis by citing a specified source (Pomerantz, 1984b), *dưới ông Dũng* ('at Dr Dung's clinic'; line 14). A resumption search is done when a speaker resumes their turn after being interrupted by another speaker. This reported information encourages Lam to check and confirm, which is receipted with his *unmarked acknowledgement* (Heritage & Sefi, 1992), *đúng rồi* ('right'; line 15). An unmarked acknowledgement (e.g., 'mmm', 'yeah', 'that's right') means doctors neither acknowledge the patient's information as new nor do they intend to follow it. This acknowledgement asserts Lam's primary right from second position (Stivers,

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²⁷ The patient answers like this presumably because she is focusing on the action of moving from one stair to the next within a flight of stairs rather than the action of ascending a whole flight of stairs.

2005a) and signifies his epistemic authority on Thu's diagnosis (Gardner, 2007).

Drawing on Thu's details, Lam employs the pre-telling format *bây giờ con hoải nghe* ('now, let me ask you'; line 17) to project two successive examples about symptoms (lines 20-21 and 24). Notice the way doctor Lam exemplifies Thu's basic movements and daily activities in these examples, which is in line with the principle of problem attentiveness. The first example describes Thu's walking, sitting down, or standing up (lines 20-21) while the second illustrates her walking down a flight of stairs (line 24). These elicitors are not declarative questions but assertions, which, through the deployment of such *lexical stance markers* (Heritage, 2012) as *mô nã* (line 21) and *a nã* (line 24), look for alignment rather than non-alignment. Lexical stance markers (e.g., intensifiers, modals, or hedges) are used to reflect the speaker's attitude toward, or evaluation of, information. Lam uses these linguistic resources to assert his commitment to Thu's severe condition based on his medical experience as a doctor. Both examples contain detailed descriptions. As a consequence, these elicitors only obtain minimal information in the form of confirmation (lines 22-23 and 25). All in all, these example elicitors restrict themselves to a particular propositional content, making it difficult for Thu to make further elaborations, and consequently withhold information that may be a valuable resource for optimal pain management interventions.

Section 6.2 has shown how doctor use of general elicitation and detailed elicitation in the course of seeking information about symptoms is partly shaped by their epistemics about the issue at hand. For example, based on her abrupt shift in focus to a new concern, doctor Quynh in Extract 6.3 seems to have little knowledge of Vuong's haemorrhoids. Hence, she uses a general question to encourage Vuong to disclose as much information as possible. In contrast, doctor Lam in Extract 6.4 appears to fully grasp the symptoms of Thu's kneecap problem. This is manifested in his sequence management throughout the extract: his diagnosis (line 11), and his subsequent unmarked acknowledgement in response to Thu's diagnosis (line 15). Therefore, Lam's example practice displays that he has good access to Thu's problem, and consequently he does not wish to elicit as much information as Quynh does.

6.3 Causes of the problem

Finding out the cause of the problem enables doctors to arrive at a diagnosis quickly,

which, in turn, informs their treatment recommendation. The doctors in this study implement different strategies in pursuit of the cause of the problem, depending on its nature. Overall, they trace the patient's problems to three main causes: accidents (Section 6.3.1), daily routine (Section 6.3.2), and physically-demanding tasks (Section 6.3.3). Besides those causes, one patient traces her problem to the side-effects of the medication she took for another problem, and one patient acknowledges that he has not complied with previous health providers' treatment recommendation, and assumes that this has brought on his problem.

6.3.1 Accidents

Consider Extract 6.5 below. It is a first visit between doctor Quynh and patient Phuong, who is in her early forties and has had chronic sciatica and a herniated disc for three or four years. This extract is taken after the elicitation of problem presentation and duration. In this extract, Quynh traces Phuong's problem to a fall (line 35) and injuries (line 39).

```
Ex. 6.5: B 1 & 1

34 D:→  trước+đây  cũng     đau   như   ri
Quynh   before     as+well  pain  same  this

35         [không  bổ    không  té::::]
            no      fall  no     fall

           'This pain came before as well, and it didn't result from a fall'

36 P:      [trước+đây              ]  cũng  [*đau*]
Phuong     before                      also  hurt

           'It also hurt before'

37 D:                                      [khô::]ng chi hết    a?
Quynh                                       no        any at+all INT

           'of some sort?'

38 P:      [°/không° ]
Phuong     no

           'No'

39 D:→  [có      ] chấn+thương chi trước  khô:ng?
Quynh    PRT        injury      any before INT

           'Did you have any injuries before?'

40         (0.6)

41 P:      °khô:ng°
Phuong     no

           'No'

42         (0.2)
```

```
43  D:→   à:: (.) #không#+có =↑tự+nhiên
Quynh     oh    not        for+some+reason

44        [#hắn# đau   thôi ºhiº?      ]
          it    hurt  only INT

          'Oh, you didn't. It hurts for some reason or other?'

45  P:    [↑chắc  hồi   nhỏ:  #cũng#] có  bổ    mà #không# chắc (.)
Phuong    probably when small also    PST fall but no      sure

46        hồi   nhỏ          thôi=hồi  con+GÁI  thôi
          when childhood   only when girlhood only

          'Probably, I fell when I was small, but just during my childhood-
          my girlhood'

47  P:    =hắn bổ   >rồi   là  rồi<  thôi chơ hắ:n(.) >có có< chi    mô:¿
Phuong    it   fall finish COP finish only but it         have nothing at+all

          'The fall didn't have any consequences at all'

48  D:    ºdạ:º
Quynh     OK

          'OK'

49  P:    bờ  đến khi  giờ+chừ thấy tuổi ló::n rồi mờ
Phuong    and to  when now    feel age  old   PRT but

50        #hắn# đau  ri          #không# biết nữ:a,
          it    pain like+this  not     know PRT

          'and, after all this time, I'm still in pain now and I don't know
          why'

51  D:    dạ
Quynh     OK

          'OK'

52        (0.2)

53  P:    do:: cái bổ   nó   hay+là:::(.) hay+là do:  mình:::::(.)
Phuong    due+to CLA fall that or            or     due+to my

54        làm+việc (.) hay+là mình- do     ºmình ngồiº a
          work          or     my    due+to my    sit  PRT

55        =[em            cũng #không# rõ    (nữa)]
          younger+sister PRT  not     know PRT

          'I don't know whether it's due to that fall, my work, or sitting
          for long periods'
```

Doctor Quynh seeks to elicit the cause of the pain by referring to a common kind of accident: a fall (lines 34-35 and 37). She constructs a three-part list in which *khô::ng chi hết* ('of some sort'; line 37) is served as a generalised list completer to locate *bổ* ('fall'; line 35) and *té::::* ('fall'; line 35) as members of a class (Jefferson, 1990). This question contains three negative-polarity items *không* ('no'; lines 35 and 37); this repetition is tilted towards a negative 'no'-answer (Heritage & Robinson, 2011; Heritage, Robinson, Elliott, Beckett, & Wilkes, 2007). However, it embodies

cross-cutting preferences of grammar and action[28] (Schegloff, 2007), which means that a 'yes' answer is expected. Seeing that Phuong also had the same problem, *trước đây cũng *đau** ('it also hurt before'; line 36), Quynh supposes that Phuong had an accident in the past. Thus, Quynh quickly recycles her turn, replacing *bổ* ('fall'; line 35) and *té* ('fall'; line 35) with a broader term, *chấn thương* ('injuries'; line 39), in an emphasised fashion. This recycled question is designed using the pair of words *có…không?* ('did you [have any injuries before]?'; line 39) that minimises Quynh's certainty of her presupposition (see Section 2.3.3.1), and to indicate no preference for the polarity of the answer. After a 0.6-second silence (line 40), Phuong re-produces her 'no' answer in a lowered volume (symbolised by degree signs; line 41), which communicates her uncertainty about her own answer.

Although Phuong twice confirms the absence of any accidents in the past (lines 38 and 41), Quynh projects a reaffirmation in lines 43-44. This three-TCU turn is prefaced with a news marker, *à* ('oh'; line 43), that proposes Quynh's acknowledgement of her incorrect presupposition in previous questions. She continues with a partial repeat of *#không#* ('[you] didn't'; line 43) delivered in a clipped fashion, and ends with a declarative question, *tự nhiên hắn đau thôi hi?* ('it hurts for some reason or other?'; lines 43-44). In the last TCU, Quynh strategically replaces the words *bổ* ('fall'; line 35), *té* ('fall'; line 35), and *chấn thương* ('injuries'; line 39) in previous questions with contrasting words, *tự nhiên* ('for some reason or other'; line 43), to register her receipt of Phuong's answers. This question triggers Phuong's admission of her fall in the past with plausible explanations (lines 45-47, 49-50, and 53-55). Quynh's go-aheads (lines 48 and 51) encourage Phuong's further elaboration on her description, hence obtaining more information about Phuong's life-world.

Extract 6.5 displays doctor Quynh's interactional strategies in the course of attributing Phuong's pain to her past accident. One noteworthy point is her formulation of three different questions (all arrowed) at different points in time. The first question, *trước đây cũng đau như ri không bổ không té không chi hết a?* ('this pain came before as well, and it didn't result from a fall of some sort?'; lines 34-35 and 37), is an alternative question with a cross-cutting preference for a 'yes' answer. As stated before, this question is initiated right after the problem duration (i.e., three

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[28] In cross-cutting preferences of grammar and action, the action of the question is designed for a 'yes', but its grammatical format is designed for a 'no'.

or four years; data not shown). This duration communicates that Phuong has chronic pain. However, given that chronic pain is less likely to affect a young patient such as Phuong than an old patient, Quynh displays that accidents are likely to be the main causes, as evidenced in this 'yes'-preferred question, which is consistent with her second question, *có chấn thương chi trước không?* ('did you have any injuries before?'; line 39). This question comes out at the junction of the overlapping talk, where Phuong says *trước đây cũng đau* ('it also hurt before'; line 36). From this information, Quynh probably thinks that Phuong was likely to have had an accident in the past (line 39). Having elicited Phuong's confirmation of no accidents twice, Quynh produces the last question, *tự nhiên hắn đau thôi hi* ('it hurts for some reason or other'; lines 43-44). Through this question, Quynh encourages Phuong to explain the cause given that it is not an accident, at least thus far.

Along with these questions, doctor Quynh uses different discursive resources to link to 'accident'. Despite its specific meaning, the first lexical items *bổ* ('fall'; line 35) or *té* ('fall'; line 35) is more neutral in meaning than *tai nạn* ('accident'). Given that Phuong might have suffered from some kind of accident other than *bổ* ('fall') or *té* ('fall') from her overlapping talk at line 36, Quynh replaces this term with a more general one, *chấn thương* ('injuries'; line 39), in her second question. Lastly, upon receiving the confirmation from Phuong, Quynh employs the phrase *tự nhiên* ('for some reason or other'; line 43). In short, the fact that Quynh does not use the word *tai nạn* ('accident') aligns with the principle of optimisation.

While doctor Quynh identifies the possible cause of the problem as an accident, Phuong expresses a divergent view on her claims. In response to Quynh's elicitation of a previous accident, Phuong projects her speculation about the cause (lines 45-47, 49-50, and 53-55) through three hypotheses: *bổ* ('fall'; line 53), *làm việc* ('work'; line 54), and *ngồi* ('sitting'; line 54). In launching this, patient Phuong, on the one hand, resists Quynh's presupposition that *bổ* ('fall') is the main cause of her problem, but on the other, implicitly voices other possible causes that she believes to be more plausible. This resistance is foreshadowed beforehand, when she rejects the pain as being caused by her fall in the past (lines 45-46). However, at the end of her turn, Phuong displays a lack of certainty with *em cũng không rõ* ('I don't know'; line 55) as a face-saving strategy to leave the final decision to Quynh's expertise.

Extract 6.5 has highlighted the fact that, despite the doctor's agenda, patients

can mobilise resources to resist a doctor's claim regarding the cause of the presenting problem. Their resistance is derived from their territory of knowledge about the concerns themselves, as they have lived with or suffered from them for a long time.

6.3.2 Daily routine

Besides accidents, some of the presenting problems have no identifiable cause. In this situation, doctors often work to link the cause of the problem to the patient's daily routine. Extract 6.6 is a DDF between doctor Quy and patient Ngoc. Ngoc has had a contorted mouth and pounding in her right ear for two months, and has achieved about 80% recovery since her first visit (data not shown). This extract occurs after Quy elicits the duration of the problem and undertakes a brief physical examination (see Extract 5.7). Quy traces Ngoc's problems to various causes: taking a cold shower (line 33), going out somewhere (line 33), sleeping with a cooler on (line 73), catching a cold (line 153), staying in the rain (line 156), and sleeping with the air-conditioning on (line 157).

```
Ex. 6.6: B 12 & 56

31  D:→  ờ  trước+khi  bị::     là  chị:::        à::::::  (0.4) trước+đây
    Quy  uh before     problem  COP older+sister  uh             before

32       =khi bắt+đầu- (0.5) bắt+đầu phát+hiện bị      là  chị
             when begin         begin   aware     problem COP older+sister

33       TẮ::M  lạ:nh  hay+là  đ- đi đâu        không?
         shower cold   or         go somewhere INT

         'Before the problem began, when you became aware of this problem,
         had you just taken a cold shower or been out somewhere?'

34       (0.7)

35  P:   ờ:: (.) đi  chợ:  về  là  thấy bị:
    Ngoc uh      come market back COP aware problem

         'I'd just come back from the market when I became aware of it'

36       (0.5)

37  D:   hư?
    Quy  huh

         'Huh?'

38       (0.3)

39  P:   đi   chợ:  về  là:::: (0.5) tự+nhiên     bửi:: (.)  SÁ:NG
    Ngoc come market back COP           unexpectedly in         morning

40       a (0.4) đến  chiề:u   là  thấy  bị      thôi
         PRT     till afternoon COP aware problem PRT

         'I came back from the market in the morning, and I became aware of
         the problem in the afternoon'
```

155

```
41       (2.8)

42  D:   hừ::::::::::
    Quy   mmm

         'Mmm'

43       (14.3)

44  D:   khi  đi  chợ     về  (.)  là  phát+hiện  (.)
    Quy   when go  market  back      COP aware

45       là  mắt (.) là  nhắm  không  kín         (.) hay+là:-=
         COP eye      COP shut   not    completely      or

         'You were aware that you couldn't shut your eyes completely as
         soon as you came back from the market, or-'

46  P:   =khô::ng (.)  không  phát+hiện  được  (0.5) đến  chiề:u    tối
    Ngoc  no            not    aware      can          till afternoon late

47       mới  phát+hiện
         PRT  aware

         'No. I wasn't aware of it. It was not until the late afternoon
         that I became aware of it'

48       (0.5)

49  D:   [ừ::  ]
    Quy   mmm

         'Mmm'

50  P:   [chiều]   tối   súc+miệng là  thấy  nướ:c  nó- hhh (0.7) tu:a  ra::
    Ngoc  afternoon late  gargle    COP see   water  it                run  out

51       thành [mới-]
         so    PRT

         'I gargled in the late afternoon and saw the water running out, so
         I-'

52  D:         [là ]bửi  sá::ng #là# chưa  bị: (.) bửi  trưa chưa bị     à?
    Quy         COP  CLA morning COP  not   start   CLA  noon not  start INT

         'You mean that the problem didn't start in the morning or around
         noon?'

53  P:   ↑chu:::a (0.5) thế+là- (.) buổi  tố:::i (0.4) đi tập thể+dụ:c (0.2)
    Ngoc  no             so         CLA   evening      go do  exercise

54       a- đi bộ::: (0.5) về   tự+nhiên- thấ:::::y (0.7) đánh  dăng
         PRT go jogging     return surprise  find              brush teeth

55       thì thấ:::y (.) nướ:c  cứ::: (0.3) DA: ngả  ni
         COP find         water  keep        out side this

         'No. When I returned home from exercising- from jogging in the
         evening, I brushed my teeth, and I was surprised to find water
         running out of this side of my mouth'

56  P:   thế mới bả::o (0.2) con   là: (0.2) nhìn+sâ::m (0.3)
    Ngoc  so  PRT ask        child COP       look

57       mặt  [mẹ bị     thế+nào ]
         face mum suffer  what

         'so I asked my child to look at what was wrong with my face'

58  D:        [thì buổi sáng   ] là  bị::  rồ::i   (0.2)
    Quy        COP  CLA morning   COP start PERF
```

```
59        đá::nh  ra-    #tập#  thể+dục  về       là  bị    rồi  chơ::?
          brush   teeth  do     exercise return   COP start PERF INT

          'So the problem must have started in the morning when you brushed
          your teeth- after exercising?'

60        (0.4)

61  P:    sá:ng   là   không  bị:
  Ngoc    morning COP  not    start

          'It didn't start in the morning'

62        (0.8)

63  P:    bị:    nhưng+mà:: m- (.)  không  phát+hiện  được
  Ngoc    start  but               not    aware      can

          'It started in the morning but I wasn't aware of it'

64  D:    tức+là   chưa  phát+hiện
  Quy     mean     not   aware

          'This means you weren't aware of it'

65        (.)

66  P:    [chưa  phát+hiện]
  Ngoc    not    aware

          'I wasn't aware of it'

67  D:    [ngủ:+dậy  là    ]  bị    rồi
  Quy     get+up     COP      start PERF

          'The problem had started before you got up'

68        (0.4)

69  P:    [vâ:ng]
  Ngoc    yes

          'Yes'

70  D:    [nhưng]+mà chưa  phát+hiện
  Quy     but        not   aware

          'but you weren't aware of it'

71  P:    chưa  phát+hiện
  Ngoc    not   aware

          'No, I wasn't'

72  D:→   rúa  tố::i  hôm  đó   là  chị          tắ:m   lạnh hay+là
  Quy     PRT  night  day  that COP older+sister shower cold or

73        chị::      (0.2)  nằ:m  quạ:t  chi lạnh  không?
          older+sister       sleep cooler any cold  INT

          'So did you take a cold shower or sleep with a cooler on that
          night?'

74        (1.0)

75  D:    nhớ+[lại  ] cho KỸ::    để-
  Quy     remember     PRT correctly to

76  P:        [không ]
  Ngoc        no

          'No'
```

```
77  D:    =không- không vì    lý-   hai lý+do (0.2) lý+do (0.4)
    Quy           no   because reason two reason       reason

78        một (0.4) do   lạnh (0.4) là  khác   (0.5)
          one       cause cold       COP another

79        do   viê:m+nhiễ:m là  khác    (.) [do]
          cause inflammation COP another     due+to

          Lines 75 & 77-79: 'Try to remember correctly for two reasons. A
          cold is one possible cause, inflammation is another. Due to-'

80  P:                                    °ù[:°]
    Ngoc                                   mmm

          'Mmm'

81  D:    bị    tai+giữ:a  tai  đồ  là [khác  ]
    Quy   cause middle-ear ear  any COP another

          'a middle-ear infection of some sort is another possible cause'

82  P:                                  [khô:ng ]
    Ngoc                                 no

          'No'

83        (1.2)

84  D:    rứa- rứa tại+[vì::]
    Quy        so  due+to

          'So it's due to'

85  P:              [mà:-] (.) mấy+bữa bị    là  bắt+đầu nó ĐA:U
    Ngoc             PRT        when    suffer COP begin   it pain

86        cái cái- cái- cái cái TA:I ni+nầy (0.4) thì  bắt+đầu châm+cứu
                              CLA ear  this         then begin   acupuncture

87        là  nó  hế:t r:::- (.) mới bảo là (.) bác+sĩ nói là  nó  ké::o
          COP it  go   so        PRT say COP    doctor say that it  strain

88        cá::i (0.2) dây+thần+ki::nh-nh-nh (0.7) làm+cho [đau     ]
          CLA         nerve                       cause    pain

          'When the pain began, it was in this ear. Then it went away thanks
          to acupuncture, so the doctor said that the pain had been caused
          by a nerve strain'

89  D:                                              [bị    cái]
    Quy                                              suffer CLA

90        TA:I này  bị    chảy    mủ: không?
          ear  this suffer come+out pus INT

          'Have you had any pus come out of this ear?'

91        (0.3)

92  P:    KHÔNG (.) #không#  bị     chi hế:t¿
    Ngoc  no        not      suffer any at+all

          'No. Nothing'

          ((60 lines deleted))

153 D:→  rồ::i (0.3) trước+khi ù+tai   là  chị         có bị::: lạ:nh
    Quy  so          before    tinnitus COP older+sister PRT catch cold

154      đì  chi không?
         thing any INT

          'So, before you developed tinnitus, did you catch a cold or
          something similar?'

                                   158
```

```
155        (0.6)

156 D:    bị  TẮM   lạnh hay+là bị    nào   bị   mu:a hay+là bị
  Quy    get shower cold or      suffer such+as stay rain or      suffer

157      tối  nằm  quạt  lạnh hay phòng điều+hòa      lạnh không?
         night sleep cooler cold or  room  air-conditioning cold INT

         'because of a cold shower, staying in the rain, or sleeping at
         night with a cooler or the air-conditioning on?'

158      (1.3)

159 P:   không (0.5)  #không thấy#  chi  ſhế:t
  Ngoc   no           not    see    any  at+all

         'No. Nothing'

160      (0.5)

161 D:   hừ::
  Quy    mmm

         'Mmm'
```

At various points throughout the consultation, doctor Quy makes three attempts (all arrowed) to link the cause of Ngoc's problems to her daily routine. The first question (lines 31-33) is concerned with two activities: *tắm lạnh* ('cold shower'; line 33) and *đi đâu* ('[had you] been out somewhere?'; line 33). However, only the latter activity is addressed, *đi chợ: về* ('[I'd just] come back from the market'; line 35). Having received an *open class form* (Drew, 1997), *hư?* ('huh?'; line 37) from Quy, Ngoc adds the point in time when the pain starts, *chiề:u* ('in the afternoon'; line 40), not *SÁ:NG* ('in the morning'; line 39). Open class form of repair initiation (e.g., 'pardon?' or 'what?') is used when the speaker treats the whole of the prior turn as problematic, and thus seeks a repeat or paraphrase. After a delay of 2.8 seconds (line 41), Quy receipts Ngoc's information with a *weak token* (Gardner, 2001), *hừ::::::::::* ('mmm'; line 42), that communicates Quy's low involvement in the information disclosed by Ngoc. However, after the lapse, Quy re-engages talk with another hypothesis on the point in time when the pain starts, *khi đi chợ về* ('as soon as you came back from the market'; line 44), that is, in the morning. Ngoc immediately rejects Quy's hypothesis and emphasises the mentioned time, *chiề:u tối* ('late afternoon'; line 46). On receipt of Ngoc's confirmation that the pain started in the late afternoon, Quy poses a declarative question (line 52) employing two different points in time, *bửi sá::ng* ('in the morning') and *bửi trưa* ('around noon'), to contrast with Ngoc's time, *chiều tối* ('in the late afternoon'; line 50). Ngoc confirms Quy's information, narrates the moment when she found water running out of her mouth in

the evening (lines 53-55), and describes how she dealt with this problem (lines 56-57). The whole narrative orients to a justification of her rejection of Quy's hypothesis. Despite this, Quy presupposes that the problem started in the morning through another declarative question that looks for a 'yes' answer (lines 58-59). Ngoc once again rejects Quy's hypothesis (line 61), but after a 0.8-second pause (line 62), rejects her own claim and acknowledges Quy's hypothesis (line 63). Departing from Ngoc's acknowledgement, Quy projects several utterances to direct the conversation to his own agenda: the problem starts in the morning before Ngoc gets up (line 67) but Ngoc is not aware of it (line 71).

Having secured the point in time when the problem starts, doctor Quy goes back to his unanswered question in lines 31-33 by recycling it to elicit the daily routine: *tắm lạnh* ('cold shower'; line 72) or *nằm quạt chi lạnh* ('[did you] sleep with a cooler on?'; line 73). This question receives two overt negative markers, *không* ('no'), from Ngoc: one (line 76) responding to Quy's elicitation (lines 72-73) and one (line 82) to Quy's explanation (lines 75, 77-79, and 81). It also receives one acknowledgement token (line 80) that communicates Ngoc's grasp of Quy's implication. Quy's attempt to project another question (line 84) is interrupted by Ngoc, who then shifts the topic to the past diagnosis and treatment at another hospital (lines 85-88). This shifting topic creates a new sequence of talk related to the chronological order of tinnitus and contorted mouth (data not shown). Taking *ù tai* ('tinnitus'; line 153) as the point in time, Quy continues eliciting the cause of Ngoc's problem (lines 153-154). Ngoc's silence (line 155) indicates her resistance to Quy's hypothesis. Facing no uptake from Ngoc, Quy elaborates on his question by giving several examples focusing solely on linking the symptoms to being cold: *tắm lạnh* ('cold shower'; line 156), *mưa* ('rain'; line 156), *nằm quạt lạnh* ('sleeping … with a cooler [on]'; line 157), *phòng điều hòa lạnh* ('the air-conditioning on'; line 157).

In terms of content, Extract 6.6 displays doctor Quy's persistence in linking the cause of the problems to Ngoc's daily routine. It is noticeable that all three attempts (all arrowed) incorporate the emphasised *tắm lạnh* ('cold shower'), which means that this is the most likely cause of the presenting problems in the eyes of the expert Quy. Another possible cause, sleeping with a cooler on, is mentioned twice, given that this kind of pain occurs at night. As both assumptions are rejected, Quy then gives more examples relating to cold (i.e., staying in the rain, and sleeping with

the air-conditioning on) without forgetting the previous possibilities (i.e., cold shower and sleeping with a cooler on). Basically, taking cold showers and sleeping with a cooler on are routine activities at the time of year in Vietnam when this recording was made (i.e., summer).

Interactionally speaking, Extract 6.6 exposes the local negotiation of meaning between a health practitioner and a patient in which their epistemics play a crucial role in their organisation of talk. At the beginning of the extract, Ngoc discloses that her health problem started in the afternoon (line 40). However, through his declarative questions and hypotheses (lines 44-45, 52, and 58-59), Quy locates the starting time in the morning, which leads to Ngoc's inconsistency within her own claim (line 63). Taking advantage of this inconsistency, Quy turns his presupposition into a fact (lines 64, 67, and 70). Quy's strong epistemic stance is also manifested in his persistence in making presuppositions about the cause of Ngoc's problem. Even though Ngoc rejects his presuppositions several times in lines 76, 82, and gives a non-answer response in line 35, Quy persists in tracing the cause to Ngoc catching a cold. Overall, Quy's interactional management reflects his expertise in this type of problem.

6.3.3 Physically-demanding tasks

According to a quantitative study conducted by Thorslund, Wärneryd, and Östlin (1992), there is a connection between ill-health and work. In other words, physical labour can negatively affect people both physically and psychologically (Kobayashi, 2004). Given this, doctors in the present study often ask about a patient's occupation. If patients are elderly or retired, doctors elicit their past occupation or the general features of their past occupation. If patients are young, doctors ask about their current job. There are two types of occupation that patients consider the main causes: temporary task and permanent job. Temporary tasks refer to physical work that patients have undertaken recently, while permanent jobs are work undertaken over a long period of time. Extract 6.7 illustrates how doctor Tung elicits patient Hong's past permanent occupation. Hong has a chronic herniated disc for which she has received two previous courses of treatment, and this is the third course. While doing the physical examination, Tung asks about Hong's previous occupation (line 121).

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Ex. 6.7: B 6 & 62

121 D:→  trước+kia  hay    gánh+gồng  nhiề:u  lắm   à?
  Tung    past      often   carry      much    very  INT

         'You often carried heavy loads in the past?'

122      (0.6)

123 P:   ừ:: (0.2) gá:nh  mà: (.)  bốc   nặng
  Hong   yes        carry  and     load  heavy

         'Yes, I carried and loaded heavy things'

         ((11 lines deleted))

134 D:→  giừ        ở  nhà:  có  làm  chi  hơn   nữa+khô:ng?
  Tung   currently  at home  PRT  work  any  other  INT

         'Are you currently doing any other work at home?'

135      (0.8)

136 P:   ở    dà:   mới  [#một# thá:ng ni ]
  Hong   at  home  just  one    month  now

         'I stopped working just one month ago'

137 D:                   [ở   dà:   mà    ] nghỉ  thô:i,
  Tung                    at  home  to      rest  PRT

         'Have a rest at home'

138 P:   nghỉ  thô::i (.)  °ừ°
  Hong   rest  only        yes

         'Rest only, yes'
```

From patient Hong's presentation of her concern (i.e., a herniated disc; data not shown), Tung presupposes that the presenting problem could have been caused by Hong's physically demanding job in the past. Hence, Tung poses a B-events declarative question ending with the interrogative particle *à* to convey this (line 121). He prefaces this question with a temporal marker, *trước kia* ('in the past'), that indexes it as a past event. He does not ask about the specific occupation (e.g., 'what do you do?'), but targets a general feature concerning blue-collar jobs instead, *gánh gồng* ('[you often] carried heavy loads'; line 121). This piece of information turns out to be useful for him in assessing the effects of Hong's previous occupation on her health. If Tung elicits the job, he would presumably ask at least one more question to know the tasks of that job (e.g., 'what tasks did you often perform?'). The present design thus saves him from producing a series of questions, which is time efficient in a time pressed system. In doing this, Tung is adhering to the

principle of recipient design[29] (Sacks et al., 1974). After 0.6 seconds of silence (line 122), Hong gives a conforming answer, *ừ::* ('yes'; line 123), following an expansion to intensify the heavy work, *gánh mà bốc nặng* ('I carried and loaded heavy things'; line 123). Her answer orients to the undertaking of a long-term job in the past, and treats Tung's presuppositions as correct.

The consultation continues with a physical and verbal examination for 11 lines (data not shown), then doctor Tung asks another question regarding Hong's current occupation at home (line 134). Compared with the first question (line 121), this one (i.e., *có…không* format) displays Tung's uncertainty towards the information proposed (see Section 2.3.3.1). He assumes that Hong, who is in her late fifties, is not so old that she should be retired from working, especially as she is a blue-collar worker. Nevertheless, Hong generates a response that conforms to neither the question's action nor its topical agenda (line 136). There may also be non-vocal aspects of the response during the gap in line 135. Without waiting for Hong to complete her turn, Tung makes a *post-start-up overlap* (Gardner & Mushin, 2007) to offer advice on taking a rest for the sake of her presenting problem (line 137). A post-start-up overlap occurs when one speaker begins their talk a little after another has started. This advice receives alignment from Hong (line 138).

In Extract 6.7, doctor Tung has strategically constructed his two questions (both arrowed) in conformity with the principle of recipient design. These questions are based on the patient's demographics and medical problems. In addition, Tung's word selection in eliciting information concerning blue-collar jobs shows sensitivity to the nature of Hong's previous job. Overall, his course of action adheres to the fundamental principles that guide medical questioning.

6.4 Duration of the problem

Information about pain duration is important to the consultation as a whole. First, duration information can serve the purpose of formulating a template for assessment in patients with acute and chronic pain (Beatty & Joffe, 2006; Fink, 2000). Second, it keeps doctors updated on the effects of the patient's previous treatments. Third, getting access to the duration sheds light on the development and intensity of the

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[29] The principle of recipient design refers to the "multitude of respects in which the talk by a party in a conversation is constructed or designed in ways which display an orientation and sensitivity to the particular other(s) who are the co-participants" (Sacks et al., 1974, p. 727).

pain since its onset. Lastly, this information offers doctors insight into the patient's healthcare beliefs and responsibilities for their well-being generally.

Eliciting information about the duration of the problem usually occurs in first visits and DDFs. SDFs do not often include this information as doctors have usually covered it in the previous meeting. Overall, there are no differences in the data set between first visits and DDFs in terms of how doctors seek the duration information. The doctors in this study pursued three strategies for eliciting this information: general elicitation, detailed elicitation, and general-to-detailed elicitation. These strategies are categorised based on the content each question aims to obtain. In particular, doctors use general questioning to look for a general answer, while specific questioning elicits a specific answer. General-to-detailed elicitation refers to a strategy in which doctors often begin with general questions, and then move gradually on to detailed ones in order to explore a specific possibility directly (Bickley & Szilagyi, 2013). This strategy enables doctors to obtain an initial picture of a patient's problem from their perspective, and focus on the particular areas that do not clearly emerge from the patient's disclosure (John, 2013). Overall, the doctor's use of general-to-detailed elicitation significantly shapes the patient's disclosure (J. Silverman et al., 2013).

In Extract 6.8, I illustrate how doctor Tuan uses a general-to-detailed elicitation technique to elicit patient Dung's pain duration (arrowed). Dung has a herniated disc, which was operated on in a different health centre. He now goes to this hospital for long-term rehabilitation without any operation.

```
Ex. 6.8: A 2 & 12
19  D:→   đau      ri    lâu   chu:a?
 Tuan    painful  this  long  INT

         'Has the herniated disc been painful for a long time?'

20        (0.9)

21  P:    cũ::ng  à:::::  (.)   mớ:::::i (0.3)  phát+lại   đâ::::y  khoả::ng
 Dung    PRT     uh            just           come+back  recently about

22        à::: (.)  hơn  #một#  tháng  rồ:i
          uh        over one   month  PRT

         'It came back for over a month'

23        (0.4)

24  D:    à::::: (.)  hồi   trước   ở+đây  có   đau
 Tuan    oh          time  before  here   PST  hurt

         'Oh. It used to hurt here before'
```

164

```
25        (.)

26  D:→  cách+đây  mấy      năm  rồ:i?
 Tuan    ago       how+many year PRT

         'How many years ago?'

27        (0.4)

28  P:   kỳ   trước là  mổ      à:::::::::::::::::::: (0.2)
 Dung    time before COP operate uh

29       ri  là  bảy   năm  rồi  đâ:y¿
         so  COP seven year PERF PRT

         'I had it operated on seven years ago'
```

After securing the major concern and its symptoms (data not shown), doctor Tuan asks Dung about the duration of the problem (line 19). He uses an alternative question with a *marked terminal intonation contour* (Ford & Thompson, 1996; symbolised by level and rising intonation) at the interrogative marker *chư:a* (line 19) to signal an information-seeking act. This question is general in two respects. On the one hand, the word *lâu* ('long') does not convey the temporal dimension. On the other, its syntactic structure predisposes Dung to a 'yes' or 'no' rather than give a phrasal or clausal response (Ford & Thompson, 1996; Lee, 2012). Although these linguistic features might be expected to constrain the next action, Dung's delayed answer discloses more information than was sought (lines 21-22). It conforms to the topical agenda of Tuan's question but does not adhere to its format constraint. In *mới phát lại đây* ('it came back'; line 21), Dung intentionally announces his medical history and discloses the duration. He suffered from this pain before, but it was cured completely. Dung delays the measurement phrase *hơn một tháng* ('over a month'; line 22) with a long stretched chunk of talk, *cũ::ng, à:::::, mớ:::::i, đâ:::::y, khoả::ng, à:::*, two pause-fillers *à* ('uh' in the gloss), and three pauses (two micro pauses and a 0.3-second pause). According to Lee (2012), delays and prefaces are common features of a clausal response. They indicate Dung's trouble with the epistemic implication that an exact number needs to be specified.

Departing from Dung's response, doctor Tuan produces another turn of talk composed of three TCUs (lines 24 and 26). The first one is an *à*-preface ('oh'; line 24) to propose his change-of-state from not-knowing to knowing. This uptake marks his receipt of the information delivered by Dung and treats this information as new. Tuan then expands his turn to add a logical inference about the pre-existence of the pain (line 24) and, on this basis, launches another question about its duration (line

26). The format 'oh + question', in Heritage's (1984a) terms, highlights its interest to Dung and thus encourages further elaboration. Dung's response in lines 28-29 fills the information gap created by that question.

Extract 6.8 shows doctor Tuan's formulation of two questions in search of the pain duration (both arrowed). As to the key lexical items, the marker *lâu* ('long'; line 19) in the first question is rather vague as it does not specify the exact duration of the pain and is not based on any fixed scale. With this marker, it is acceptable for Dung to provide an equivocal answer, for example, *lâu rồi* ('a long time'). The answer *lâu rồi* ('a long time') can be too general for Tuan to gauge its duration, as Dung's concept of 'long' may not correspond to his own. For Dung, five months might be long enough to endure such pain, whereas Tuan, who elicits this information from numerous patients every day, may have a different scale (see also Extract 6.9). The second question employs *mấy năm* ('how many years'; line 26), which is able to build grounds for estimating the duration of the problem. With respect to their grammatical forms, the first elicitation is an alternative question while the second is a non-alternative one. Therefore, the former, as discussed, is general in terms of its topic agenda but restricted in its action agenda, whereas the latter is the opposite. In addition, detailed questioning is utilised when patients have some difficulties in grasping the doctor's general questioning, or when doctors expect a specific answer. In short, both questions seek different types of information.

Apart from using questioning, doctors also adopt a fishing device to elicit duration information. A fishing device refers to the strategy in which doctors integrate information into their utterances to seek further information. Alternatively, doctors can present their own experience, or make an assertion about a patient's condition based on their observation or inference. Typically, this strategy does not have a syntactically interrogative format, but is expressed via a statement that is positioned in the middle of a sequence of several adjacent pairs, and preceded by at least one adjacent pair that overtly elicits information about the duration of the health problem. In launching a fishing device, doctors may obtain some information from patients. Let us look at Extract 6.9 to see how doctor Lam deploys this strategy to seek patient Thao's pain duration on her first visit to this hospital (arrowed). Thao has pain from her back running down her right buttock. The following interaction occurs right after the problem presentation stage for the main concern.

10 D: *à::::::::::::::: (0.6) mà::: ră::ng? (0.4)*
  Lam   uh   but   well

11   *à đa::u (.) chắc lâu rồi hí?*
         uh pain   guess age PERF INT

         'Well. I guess you've been suffering from this pain for ages?'

12   (0.5)

13 P: *nhạ:::*
  Thao   yeah

         'Yeah'

14   (0.5)

15 D: *đa::::u (.) mấy   năm rồ:i?*
  Lam   pain   how+many year PERF

         'How many years has it been?'

16   (0.2)

17 P: *mô: mấy nă:m¿ (0.2) mới bữa tháng năm #đế:n# chù:*
  Thao   not PL year   just in month May   to   now

         'Not as long as a year. Just since May'
         ((It is July 6th, 2016 today))

18   (0.2)

19 D:→ *kí lu::ng cò::ng nơi [rồi tề::,]*
  Lam   CLA back   hunch PRT PERF   that

         'Your back's hunched'

20 P: [*từ– từ–] (0.3) tháng năm truớ:c ˡa*
  Thao   since   month May last   PRT

         'Since May last year'

21   (.)

22 D: [ˡ*đó::::::::::::::::::::*]
  Lam   right

         'Right'

23 P: [*à: một nă:m   ] rồi đâ:y¿*
  Thao   oh one year   PERF PRT

         'Oh, it's been one year'

24 D: *kí lung còng là biết đau [lâu rồ:::::::::]::i*
  Lam   CLA back hunch COP know suffer long PERF

         'Your hunched back tells me that you've suffered for a long time'

25 P: [*à::::: m–   ]*
  Thao   oh
         'Oh'

26 P: *một năm rồi đâ::y,*
  Thao   one year PERF PRT

         'One year'

From Thao's description of her back problem (data not shown), doctor Lam

elicits its duration using a general term, *lâu* ('ages'; line 11), embedded in a 'yes/no' question that prefers a 'yes' answer (lines 10-11). His elongated turn, several pauses, plus the word *chắc* ('guess'; line 11) convey uncertainty about his own claim. On receipt of Thao's confirmation, Lam projects another question using the question marker *mấy năm* ('how many years'; line 15) to narrow down the focus to the year dimension. After a brief silence of 0.2 seconds (line 16), Thao rejects his presupposition with *mô: mấy nă:m¿* ('not as long as a year'; line 17), plus an account, *mới bữa tháng năm #để:n# chừ:* ('just since May'; line 17). Despite this, Lam resists Thao's claim. Instead, he adopts the strategy of *telling my side* (Pomerantz, 1980), in order to fish for type 2 knowables based on his own observation (line 19). In medical interactions, telling my side means doctors make an assertion about something based on their observation or their inference in order to trigger patient disclosure. Type 1 knowables refer to information that patients have rights and obligations to know (e.g., their own name or age), while type 2 knowables are information that patients presumably have access to. This fishing assertion serves as a *lie-detecting device* (Bergmann, 1992), although Thao's information may be due to her absent-mindedness rather than a lie (Thao is in her early eighties). In responding, Thao projects a stuttering talk, *từ-từ-* ('since'; line 20), pauses for 0.3 seconds (line 20), and mentions the point in time as a recall, *tháng năm trướ:c* ('May last year'; line 20). She then produces a news marker, *à:* ('oh'; line 23), that signals the change-of-state in her knowledge of the problem duration before she states this duration, *một nă:m rồi đâ:y¿* ('it's been one year'; line 23). This last TCU accepts Lam's counterinforming as a correction (Heritage, 1984a), from which Lam maximises his certainty and displays his medical expertise (lines 22 and 24). Thao once again repeats her previous information as a form of correction (line 26).

Extract 6.9 is noteworthy regarding the different deployment strategies that doctor Lam draws upon to elicit information. At the beginning of the extract, Lam uses a general-to-detailed technique to narrow down the time dimension from a general (lines 10-11) to specific criterion (line 15) in which the former question is a stepping stone for the latter. However, as the conversation develops, he questions Thao's information (line 17). Facing this dilemma, Lam deploys the fishing device to propose an assertion about Thao's condition based on his own observation, *kí lư::ng cò::ng nơi rồi tề::,* ('your back's hunched'; line 19). This assertion is produced in an elongated fashion with stress on two key words *lư::ng cò::ng*

('[your] back's hunched') and a final-rising intonation (marked by a comma). Moreover, the demonstrative reference *tề::* ('that' in the gloss) implies that what Lam has mentioned is the factual evidence. Another possible reason why Thao corrects her information is the shift in Lam's description from 'pain' to 'hunched'. In short, by combining general-to-detailed technique and a fishing device, Lam is able to approach the pain duration from different angles and obtain exact information. This may enable him to arrive at a likely diagnosis and optimal treatment recommendation later.

So far Chapter 6 has discussed the doctors' elicitation of information about the current problem: recovery assessment, symptoms, causes, and the duration of the problem. The chapter now turns to the information related to the patient's medical history: (i) past diagnoses and treatments, (ii) lifestyle issues, and (iii) past problems.

6.5 Past diagnoses and treatments

Information about past diagnoses and treatments is integral to the medical history that informs the outcome of the consultation in many respects (Bickley & Szilagyi, 2013). Firstly, this information can direct and adjust doctors' current diagnosis and treatment. Secondly, it may save doctors the trouble of delivering their own diagnosis and/or treatment recommendation. Thirdly, although the diagnosis information is logically made by other health providers or from test results, patients may disclose this information to doctors as if it were the patient's own diagnosis. This disclosure may convey the patient's different expectations for the current visit. On the one hand, some want doctors to examine them again for a second opinion of the diagnosis, but, on the other, some ask doctors to proceed with treatment given that the diagnosis is available, especially from such test results as an X-ray or MRI (magnetic resonance imaging). In fact, the patient's disclosure of past diagnoses and/or treatments not only communicates their expectations for the current visit but also contributes to the development of a constructive relationship for mutual understanding between the two speakers (McDaniel et al., 1990).

In the two research hospitals, the patient's medical history is often recorded on paper, not on online software, and transferring the patient's medical information online between hospitals is not possible. Because of this, and the fact that some patients did not bring a medical record with them, doctors have to elicit this

information during the consultation. By finding out about a patient's previous visits to health centres and treatment methods, doctors can stay updated on the medicine that patients have just taken or been taking, and the tests they have had, and thereby adjust their treatment regime.

The doctor's elicitation of past diagnoses and treatments is subject to visit type. For first visits, doctors look for past diagnoses and treatments at other health centres if appropriate, while for patients who received treatment at this hospital, doctors either elicit the diagnosis and treatment previously given by another doctor (for DDF patients) or ask patients to recall the treatment methods they received on their previous visits (for SDF patients). Given this difference, I classify the diagnoses and treatments into two categories: those at other health centres (Section 6.5.1) and those at the current hospital (Section 6.5.2). In response to doctor's elicitation, patients include reasons for choosing this hospital and assessment of previous treatment.

6.5.1 Diagnoses and treatments at other health centres

Seeking information about past diagnoses and treatments at other health centres tends to take place in first visits, when the patients have received treatment elsewhere prior to this consultation. As discussed above, the research hospitals in this region specialise in traditional medicine and rehabilitation while most of the other hospitals in the region specialise in Western medicine. Therefore, the information that doctors elicit is general and related to Western medicine (e.g., the previous medical record of the problem, or whether patients have had the pain area X-rayed or not), as shown in Extract 6.10 below. This extract is taken after patient Xuan has presented all of her concerns: diabetes, hypertension, stomachache, and arthritis, of which the last is her major concern. In this extract, doctor Quynh wants to look at the test result regarding Xuan's blood sugar levels, and elicits Xuan's previous treatment for her shoulder joint (both arrowed).

```
Ex. 6.10: B 1 & 4
31 D:    bà:       bị:::   à  (.) bệnh tiểu+đuờ:ng lâu+mau
Quynh    grandma   suffer  uh     CLA  diabetes    how+long

32       rồi  đã   nã?
         PERF first PRT

         'First, how long have you been suffering from diabetes?'

33       (0.4)
```

```
34  P:   mù:i   năm  ⌐rồi
 Xuan    ten    year  PERF

         'Ten years'

35       (0.3)

36  D:   mù:i   năm?
Quynh    ten    year

         'Ten years?'

37       (0.3)

38  P:   ừ:
 Xuan    ye:s

         'Yes'

39       (0.2)

40  D:→  ừ::::  (.) <bà    có   cái  giấy+tờ chi::: à> (0.6)  đo:
Quynh    mmm        grandma have PRT  record  any    uh       measure

41       đường huyết >bà    cho   con        coai #một# xí¿<
         sugar blood  grandma give  offspring  look  a     little

         'Could I have a look at any medical records for your blood sugar
         that you've brought with you?'

42       (6.7)

43  P:   bà::    mới  sá:ng   ni   mới  đi khám  tim   về
 Xuan    grandma just morning this just go check heart return

44       đây  mà  (1.3) (không biết)  cái giấy để ở+đâu
         PRT  but        not    remember CLA paper put where

         'I had my heart checked just this morning, but I can't remember
         where I put the piece of paper with the results'

45       (1.0)

46  P:   đây  nà:y (0.3) giấy  của bệ:nh tiểu+đường đây,
 Xuan    here PRT        paper of  CLA   diabetes   here

         'Here it is. Here's the paper for my diabetes'

47       (0.4)

48  D:   dạ: (.) bà      cứ  để   đó   cho con       coi  hí¿
Quynh    yes     grandma PRT leave there for offspring look PRT

         'Yes, please leave it there for me to have a look at'

         ((101 lines deleted))

149 D:→  kí:: hóp   vai      ni   bà      có  khi+mô đi chụp phim
Quynh    CLA  joint shoulder this grandma PRT ever   go have X-ray

150      kiểm+tra chư:a?
         test     INT

         'Have you ever had this shoulder joint X-rayed?'

151      (0.2)

152 P:   chư:a (0.3) chụp (0.5) chụp- chụp phim  chư:a
 Xuan    not+yet                       take X-ray not+yet

         'Not yet'
```

171

```
153        (0.2)

154 P:    CHÂ:N  thì  có  chụ:p  (.)  đều  va:i   ni   chưa  chụ:p
 Xuan     leg   COP  PST  X-ray       but  shoulder this  not   X-ray
          'My legs have been X-rayed, but not this shoulder'

155        (0.2)

156 D:    dạ::  (.)  chứ::ng+tỏ:   chưa    chụp
Quynh     OK         mean         not+yet  X-ray
          'OK. So, that means your shoulder hasn't been X-rayed'
```

In lines 31-32, doctor Quynh seeks the duration of Xuan's diabetes. This question using the marker *đã nã* ('first') is treated as a pre-request that foreshadows the imminence of a request. As soon as Xuan confirms that she has had diabetes for ten years (line 34), Quynh asks Xuan for her medical record to support this (lines 40-41). Quynh launches her turn with a stretched hesitation marker, *ừ::::* ('mmm'), following a micro pause, before slowly producing the first part (i.e., marked by outward-pointing carets < >) to add emphasis to this chunk of talk (Hepburn & Bolden, 2012). This chunk is further stressed by the underlined words *giấy tờ* ('medical records'; line 40), which directs Xuan's attention to the piece of information that Quynh is looking for. Quynh then takes a 0.6-second pause (line 40) prior to completing her turn with rushed terminal talk. The whole turn embodies Quynh's presupposition that Xuan must have had her blood sugar checked before. At the request of Quynh, *bà có cái giấy tờ chi đo đường huyết bà cho con coai một xí* ('could I have a look at any medical records for your blood sugar that you've brought with you?'; lines 40-41), Xuan is presumably searching for the paper during a lengthy silence of 6.7 seconds (line 42). She then expands her turn of talk in the form of informing (lines 43-44) to account for the delay in locating the information that is being requested. After another 1.0-second silence (line 45), Xuan succeeds in finding the paper and gives it to Quynh (line 46). Quynh closes the request sequence by asking Xuan to leave it on the table (line 48).

The consultation continues with a focus largely on the shoulder joint pain, which has been present for three months (data not shown). In connection with this, doctor Quynh seeks another piece of information about previous X-rays of Xuan's shoulder joint (lines 149-150). She uses the pair of interrogative markers *có…chưa* to refer to the implementation of X-ray, which makes Xuan's uptake, *chư:a* ('not yet'; line 152), next relevant. Instead of terminating her turn at *chư:a* ('not yet'),

Xuan expands it at the possible TRP (i.e., a 0.2-second pause at line 153) to interpolate the information about her X-rayed leg, *CHÂ:N thì có chụ:p* ('my legs have been X-rayed'; line 154). She then re-confirms her non-X-rayed shoulder, *đều va:i ni chưa chụ:p* ('but not this shoulder'; line 154). Notably, the expanding talk is produced after three TRPs (i.e., after 0.3 seconds, 0.5 seconds, and 0.2 seconds in lines 152-153) without Quynh's uptake. In this expanding talk (line 154), the key word, *CHÂ:N* ('legs'), is produced in a stressed, prolonged, and loud fashion, which aims to focus Quynh's attention to this new information (Kidwell, 2012). By disclosing another X-ray test, Xuan indicates that she monitors her medical history quite well, and thus Quynh can trust her information of her non-X-ray shoulder. At this juncture, Quynh responds with *dạ::* ('OK'; line 156) to register her receipt of Xuan's information, and then concludes this turn with *chứ::ng tỏ: chưa chụp* ('so, that means your shoulder hasn't been X-rayed'; line 156). She does not mention Xuan's X-rayed legs. This discourse action treats Xuan's expansion as irrelevant to the current agenda.

Extract 6.10 has shown how doctor Quynh seeks past diagnosis and treatment information about Xuan's different problems at another hospital. Two questions (arrowed) have different presuppositions and designs due to the differences in Quynh's epistemic stance towards the problems that have been targeted. The first elicitation (lines 40-41) is a request that calls for Xuan's action of showing her medical record. This request eventually looks for information about the test result of her diabetes. Given such a long duration of ten years (line 34), Quynh presupposes that Xuan has had her diabetes checked several times before; thus, Xuan should know her blood-sugar levels and should have this information readily available at this consultation. Moreover, the written records would contain further information about the patient's diabetes, which may help inform the doctor's treatment recommendations. While the first elicitation is a request-for-action question, the second (lines 149-150) is a request-for-information question (Tsui, 1994) concerned with the implementation of a medical test. Due to the recency of this shoulder pain (i.e., three months), Quynh is not sure whether Xuan's shoulder has been X-rayed or not. Thereby, Quynh does not apply previous elicitation strategies to this situation but poses a question to convey her lack of knowledge towards the information sought (lines 149-150). Following this question, the consultation can take either of two trajectories. If Xuan has not had any X-ray tests, Quynh may arrange for her to

have this test later. Alternatively, if an X-ray has been done, Quynh may proceed with other information-seeking questions about the test results and previous treatment methods. When the information being requested is related to an ongoing issue, the elicitation strategy is different to when the information is concerning a new one. In other words, the doctors design their utterance to the local interactional context.

6.5.2 Diagnoses and treatments at the current hospital

As stated in Section 4.1.3, doctors are sometimes unable to collect the patient's record from the reception before the consultation. As a result, they lack the necessary background information about the patient's problem in some instances. This explains why some DDF doctors elicit information regarding past diagnoses and treatments at the current hospital. Some SDF doctors also adopt this practice because they probably fail to recall this information. Seeking past diagnoses and treatments at the current hospital only occurs in follow-up visits. As patients have received specialised treatments at this hospital before, doctors tend to narrow down the scope of elicitation to previous treatment methods for an update on the patient's recovery, and making any necessary adjustments on this basis. Additionally, doctors may also want to know which medical tests (e.g., X-ray, blood test, or urine test) patients have had, so that they can decide whether or not any new ones are indicated.

Extract 6.11 is a DDF between doctor Nguyet and patient Tran, who is seeking treatment for the pain in her back that travels down the leg. The extract is taken during the physical examination. In this extract, Nguyet elicits different treatment method information relating to traditional medicine: herb-dressing therapy[30], injection therapy, cupping therapy, acupuncture, physiotherapy, herbal steam therapy, and spinal traction (all arrowed).

```
Ex. 6.11: B 11 & 66
196 D:     đợt  vừa+rồi là  chị          nằm  phò:::ng (0.2)
Nguyet     time last   COP older+sister stay ward

197        mười+bốn ni   luôn ha?=
           14        this also INT

           'You also stayed in Ward 14 the last time you were here?'

198 P:     =dạ  hhh
 Tran      yes
```

[30] Herb-dressing therapy is a traditional treatment method in which the pain area is covered with ground herbs.

'Yes'

```
199        (0.3)

200 D:     là   bác   Gia::ng (.) [là::m] (.)
Nguyet     COP  doctor Giang        charge

201 P:                              [dạ  ]
  Tran                              yes

           'Yes'

202 D:     chỗ  nơi+đây hi?
Nguyet     ward this    INT

           Lines 200 & 202: 'Dr Giang was in charge of this ward?'

203 P:     dạ
  Tran     yes

           'Yes'

204        (0.4)

205 D:→    bó   lá   cho  chị         phải+không?
Nguyet     dress herb for  older+sister INT

           'He gave you herb-dressing therapy, didn't he?'

206        (0.7)

207 D:→    [thủy+châm      ha?]
Nguyet     injection+therapy INT

           'Injection therapy?'

208 P:     [dạ: có-         ] (.) có  rịt    với  có::: à::: (0.4)
  Tran     HON                     PST dressing with PST   uh

209        thủy+châm
           injection+therapy

           'Wound dressing and injection therapy'

           ((18 lines deleted – Physical examination))

227 D:     rúa+là vừa+rồ::i a: (.) là::: có::::: (.) bó:::(.) lá  này
Nguyet     so     last     PRT     COP   have           dress  herb PRT

           'So you had herb-dressing therapy on your last visit'

228 P:     dạ: ↑không (0.3) em          vừa+rồ::i à:::
  Tran     HON no          younger+sister last        uh

           'No. On my last visit, I-'

229 D:     là làm  chi?
Nguyet     COP do   what

           'What was it, then?'

230 P:     à::: (.) thủy+châm       với  châm      (0.3) với  đi: (.)
  Tran     uh       injection+therapy and  acupuncture      and  take

231        vật+lý  trị+liệu
           physical therapy

           'injection therapy, acupuncture, and physiotherapy'

232        (0.3)

233 D:     à::: (.) rúa  thôi hi?
Nguyet     oh       that just PRT
```

175

```
              'Oh. That's all?'

234 P:      d(h)ạ
  Tran      yes

            'Yes'

235         (0.2)

236 D:→     có  BẦU     #đồ#  rứa  không?
Nguyet      PRT cupping thing like INT

            'Did you have any cupping therapy or something like that?

237 P:      dạ  ⌈không
  Tran      HON no

            'No'

238         (0.2)

239 D:→     không ⌈ha (.) #châm#+CỨU?
Nguyet      no    PRT      acupuncture

            'No. How about acupuncture?

240         (0.8)

241 P:      dạ  ⌈có:
  Tran      HON yes

            'Yes'

242         (0.2)

243 D:      có   cứu        hi?
Nguyet      have acupuncture INT

            'You had acupuncture?'

244 P:      dạ
  Tran      yes

            'Yes'

245 D:      à::: (0.3) có   cứ:u       (.) có   thủy+châm
Nguyet      uh         have acupuncture    have injection+therapy

            'You had acupuncture, injection therapy'

246 P:      dạ
  Tran      yes

            'Yes'

247         (0.6)

248 D:→     có::-(.) >đi  vật+lý  trị+liệu là  họ   làm chi?<
Nguyet      have     take physical therapy COP they do  what

            'Had- What did they do for your physiotherapy?'

249         (.)

250 D:      họ   [(hướng+dẫn  chi) ]
Nguyet      they perform      what

            'What kind of therapy did they perform?'

251 P:           [dạ          =kéo]+giãn cột+sống
  Tran           HON            traction spine

            'Spinal traction'
```

```
252 D:      à::
Nguyet     oh

           'Oh'

253        (0.2)

254 P:      dạ:=vó:::::i (0.4)  chiếu    đè::n
 Tran      HON and            infrared light

           'and infrared light therapy'

255        (0.2)

256 D:      à::
Nguyet     oh

           'Oh'

257 P:      dạ: (0.3)  dạ  vó:i- (.) vó:i+là:: (.) XÔ:NG
 Tran      yes        HON         and           herbal+steam

           'Yes. And herbal steam therapy'

258        (0.4)

259 D:→     ù   (0.8)  xông+hơi    luôn  em            hi,
Nguyet     mmm        herbal+steam also  younger+sister PRT

           'Mmm. Also herbal steam therapy'

260        (0.2)

261 D:→     kéo+giãn cột+sống hắn  #cũng# đỡ        đó+chơ¿ (.) [hi:]?
Nguyet     traction spine    it   also   alleviate PRT             INT

           'Spinal traction also alleviates the pain?'

262 P:                                                          [dạ:]:
 Tran                                                           yes

           'Yes'

263        (0.2)

264 P:      [khô:ng]
 Tran      well

           'Well'

265 D:      [ké::o ]  xong  [thấy răng?]
Nguyet     traction  after  feel  how

           'How did you feel after that?'

266 P:                       [e:::m   ]   vô:       là (0.6)
 Tran                       younger+sister hospitalise COP

267         em            đa::u là  e:m          bắt  bên ni
            younger+sister pain  COP younger+sister have side this

268         em                      kéo+giãn cột+sống là  em            thấy đỡ,
            younger+sister          traction spine    COP younger+sister feel better

           'I felt pain on this side, but then I had spinal traction and I
            felt better'

269        (0.3)

270 D:      à:
Nguyet     oh
```

```
271 P:    cái chân em           #hắn# đỡ
 Tran     CLA leg  younger+sister  it   ease
```
          'The pain in my leg has eased'

Here doctor Nguyet maintains an exclusive focus on the traditional medicine therapies that Tran underwent during her last hospitalisation. The first question is posed at line 205 to seek a (dis)confirmation for the herb-dressing therapy. It has the format of a tag question ending with the interrogative marker *phải không* ('didn't he?'; line 205)*,* which conveys Nguyet's certainty toward the proposed information that she is seeking (see Section 2.3.3.1). After 0.7 seconds of silence (line 206) without any feedback from Tran, Nguyet proposes a second treatment: injection therapy (line 207). However, Tran does not address Nguyet's previous question until Nguyet has started this turn, which causes *turn-initial overlapping talk* with Nguyet's turn (Jefferson, 2004a; lines 207 and 208). By cutting herself off at *có-* (a particle that indicates a past action; line 208), and waiting until the completion of Nguyet's turn (line 207), Tran displays her orientation to one-at-a-time norm as an overlap resolution. Seeing that Nguyet has completed her turn (line 207), Tran makes a restart as a *marked self-retrieval* (Jefferson, 2004a), characterised by a repeat of the particle *có* after a micro pause (line 208). A marked self-retrieval means a speaker restarts the talk that has been interrupted by another speaker. This turn responds to Nguyet's two questions at the same time (lines 205 and 207). However, while Nguyet uses the term *bó lá* ('herb-dressing'; line 205), Tran responds with *rịt* ('wound dressing'; line 208). Basically, both *bó lá* ('herb-dressing') and *rịt* ('wound dressing') refer to the action of dressing something around the pain area. This may lead Nguyet to think that Tran received the herb-dressing therapy on her last visit (line 227).

Doctor Nguyet continues to elicit other treatments after a few lines of physical examination (data not shown). She prefaces this practice by summarising the treatment previously confirmed by Tran (line 227). However, Tran's 'no' upshot at line 228 treats Nguyet's summarisation as incorrect. This is due to the misunderstanding between the two terms *bó lá* ('herb-dressing') and *rịt* ('wound dressing') above. Facing this, Nguyet abandons her summarisation, and launches a new turn in the form of a general question to minimise her certainty (line 229). In asking this question, she registers Tran's next action as new to her and allows Tran

to speak in her own terms. Tran's disclosure of three treatment methods in lines 230-231 fills the gap that Nguyet's question has left. On receipt of this information, Nguyet prefaces her turn with an elongated news marker, *à:::* ('oh'; line 233), plus a declarative question, *rứa thôi hi?* ('that's all?'), to register her receipt of new information, and also terminate Tran's list. Nguyet then produces a series of 'yes/no' questions to elicit other treatment methods (lines 236, 239, and 243). Notably, the second question referring to the acupuncture treatment, *châm cứu* ('acupuncture'; line 239), has already been listed by Tran at line 230, *châm* ('acupuncture'). Although Tran confirms her receipt of acupuncture (line 241), Nguyet projects a modified repeat question (line 243) to seek Tran's confirmation again (line 244). Nguyet then launches a summarisation (line 245) to look for Tran's confirmation of *cứ:u* ('acupuncture') and *thủy châm* ('injection therapy').

From line 248 onwards, the talk revolves around physiotherapy. In lines 248 and 250, Nguyet cuts herself off at *có::-* ('and'): she most likely intends to say *có đi vật lý trị liệu* ('[you] had physiotherapy') as a continuation of her list at line 245. However, after a micro pause (line 248), Nguyet speeds up to produce a *turn-constructional pivot* (Schegloff, 1979) with *đi vật lý trị liệu* ('for your physiotherapy'; line 248) functioning as a pivot between the summarisation, *có cứu có thủy châm* ('you had acupuncture, injection therapy'; line 245), and the question, *đi vật lý trị liệu là họ làm chi?* ('what did they do for your physiotherapy?'; line 248). A turn-constructional pivot refers to an item of talk that can be seen as both the end of one grammatical unit and the beginning of the next unit (Schegloff, 1979). Nguyet's continuative intonation at *đi vật lý trị liệu* ('for your physiotherapy'; line 248) projects resumption rather than completion, and thus marks her success in securing a question about sub-treatments of physiotherapy. This question elicits further information on three other treatments: spinal traction (line 251), infrared light therapy (line 254), and herbal steam therapy (line 257), during which Nguyet uses two news markers *à::* ('oh'; lines 252 and 256) to register her receipt. When all treatments are secured, Nguyet elicits information about the effectiveness of spinal traction (lines 261 and 265), which she recommends taking again as this current course of treatment (data not shown). Of note, she embeds the word *đỡ* ('alleviates') within a 'yes'-preferred question to in order to embody a positive health outcome, which conforms to the principle of optimisation. In response, Tran elaborates on her previous treatment of spinal traction, and asserts the same evaluation (Pomerantz,

1984a) as that of Nguyet intonationally with _đỡ_ ('better' and 'eased'; lines 268 and 271 respectively). This uses a post-positioned assessment as a technique for displaying closure of turn (Goodwin & Goodwin, 1987).

Extract 6.11 has shown various formats of elicitation that doctor Nguyet designs to seek previous treatments and assessment. These elicitors are constructed in accordance with Nguyet's knowledge of Tran's previous treatments, which is both based on her expertise and experience as a doctor specialising in these treatments, and obtained through the local management of interaction between the two participants. At the beginning of the sequence, Nguyet adopts a tag question (line 205) and a declarative question (line 207) that display her strong epistemics about Tran's use of herb-dressing and injection therapy. Her course of action may have been determined by her previous knowledge of, and experience in, treating this kind of problem. However, facing a rejection from Tran (line 228), Nguyet uses other question formats to communicate her lack of access to information about Tran's previous treatments: wh-questions (lines 229 and 248) and _có…không_ questions (lines 236 and 239). In brief, the action that Nguyet's questions are implementing is largely shaped by her epistemic status, and in turn shapes the patient's response.

6.6 Lifestyle issues

In addition to the specialised information concerning the current problem itself, doctors also need some information about patients' lifestyles. Such information as eating, toileting, sleeping, or medically-related habits (i.e., the daily routine associated with patient's current concerns) provides insight into patients' life-world concerns (Mishler, 1984). It enables doctors to work out how illnesses affect patients' daily living and, on this basis, evaluate their severity. In addition, the information about minor daily illnesses like stomachache, insomnia, depression, or stress is a valuable resource for doctors to select the medication appropriately. In short, this information is of critical import to sound health care and treatment regime, according to the communication guidelines issued by the National Institute on Aging (2011).

The information about lifestyles is varied. It ranges from basic activities (e.g., sleeping, eating, and toileting) to medical ones (e.g., patients taking medication every morning). Based on the nature of the activity, I have classified them into three categories: basic activities (Section 6.6.1), medically-related activities (Section

6.6.2), and symptoms of other conditions (Section 6.6.3).

6.6.1 Basic activities

Most of the participating doctors gather information about basic activities. This information is elicited at the same time (e.g., after physical-examination stage) rather than interspersed during the consultation. Doctors look for such information as sleeping, eating, or toileting, the status of a female patient's menstrual cycle, patients' drinking or exercise habits. Consider Extract 6.12 below between doctor Hung and outpatient Tuyen, who has hypertension, blood cholesterol, and an ankle problem (the main concern). The extract is taken near the close of the history-taking and physical examination. In this extract, Hung elicits three basic activities: sleeping, eating, and toilet habits (all arrowed).

```
Ex. 6.12: B 10 & 38

248 D:→  ngủ:    được khôn?
 Hung    sleep well  INT

         'Do you sleep well?'

249      (0.3)

250 P:   ngủ    thì   #cũng#  đượ:c
Tuyen    sleep  COP   fairly  good

         'My sleep's fairly good'

251 D:   [ngủ   #cũng# được¿   ]
 Hung    sleep  PRT    well

         'You sleep well'

252 P:   [#một#  đêm   cũ:::ng] (.) BỐ:N NĂM   TIẾNG
Tuyen    one     night about       four five  hour

         'about four or five hours per night'

253      (0.2)

254 D:→  ă:n  ngon+miệ:ng  không? (.) ă:n được-
 Hung    eat  appetite     INT        eat PRT

         'Do you have an appetite? Do you eat-'

255 P:   ă:n thì ăn  rất   í:t
Tuyen    eat COP eat very  little

         'I eat very little'

256      (0.2)

257 D:   hà:
 Hung    oh

         'Oh'

258      (0.4)

259 P:   mình ăn  #một#  ngà:y  #một#  bữ::a  [chưa]+được #một#chén cơm   à
```

181

```
Tuyen     I    eat one    day    one    meal  not         one  bowl rice PRT

          'I eat less than a bowl of rice per meal per day'

260 D:                                               [°dạ°]
   Hung                                              OK

          'OK'

261 D:    nhạ
   Hung   yeah

          'Yeah'

262       (0.8)

263 D:    người  có  sợ         NÓ::NG  không? (.) hay+là  sợ
   Hung   body   PRT difficult  heat    INT        or      difficult

264       lạ:nh? (0.2) hay  [nhiề::u-]
          cold         or    much

          'Do you have difficulty coping with the heat? Or the cold? Or-?'

265 P:                        [sợ     ]  NÓ:NG
   Tuyen                       not+stand  heat

          'I can't stand the heat'

266       (0.3)

267 D:    sợ         nó::ng   ha?
   Hung   not+stand  heat     INT

          'You can't stand the heat?'

268       (0.2)

269 P:    sợ:        nó:::ng
   Tuyen  not+stand  heat

          'No'

270       (0.2)

271 D:    hừ::
   Hung   mmm

          'Mmm'

272       (0.4)

273 P:    h(h)ẽ::     về: nhà  là::
   Tuyen  as+soon+as  get home COP

          'As soon as I get home'

274 D:    à:=là bật      [quạt liề:n¿ ]
   Hung   uh COP turn+on fan   immediately

          'You turn the fan on immediately'

275 P:                        [chu::n vô ]  phòng thô::i $hê [hê::      ]
   Tuyen                        stay   in    room  only

          'I only stay in my room'

276 D:                                                    [à- à- à:::]
   Hung                                                   uh

277 P:    h[ê hê$ ]
   Tuyen

278 D:      [là bật]    quạ:t ↑thô:i
```

182

```
         Hung      COP turn+on fan    immediately

              Lines 276 & 278: 'You turn the fan on immediately'

279 P:     ừ:      ừ
Tuyen      yeah    yeah

           'Yeah, yeah'

280 D:     về  nhà  là  bật  quạ:t  lên  nằ:m  thôi¿
 Hung      get home COP turn fan    on   use   PRT

           'You turn the fan on as soon as you get home'

281        (0.2)

282 P:     dạ
Tuyen      yes

           'Yes'

283        (0.2)

284 D:     dạ:
 Hung      OK

           'OK'

285        (0.3)

286 D:→    đi+ngoà:i  đồ  răng? (.) có  bình+thường  không
 Hung      toilet     PRT how       PRT normal       INT

287        =hay+là  táo+bó::n?
           or       constipated

           'How about your toilet habits? Are they normal, or do you get
           constipated?'

288        (0.3)

289 P:     không  (.)  bình+thườ::ng  [ˡtề   ]
Tuyen      no          normal          PRT

           'No, they're normal'

290 D:                                [bì:nh]+thườ:ng  ha?
 Hung                                 normal           INT

           'Normal?'

291 P:     nhạ
Tuyen      yeah

           'Yeah'

292        (0.3)

293 D:     không  bó:n        >#không# chi  hết<¿
 Hung      not    constipated not      any  at+all

           'No constipation or any other problems at all'
```

Doctor Hung's first question (using the reduced form of *có…không*; line 248) is designed with no clear preference for a 'yes' or a 'no' response. However, instead of projecting a general question like *ngủ thế nào?* ('how's your sleep?'), Hung uses a recipient-designed question prefaced by the word *được* ('well'; line 248) on the

assumption that an elderly patient like Tuyen (who is over seventy years old) is likely to suffer from insomnia due to the age-related sleep change (Suzuki, Miyamoto, & Hirata, 2017). Tuyen answers Hung's question (line 250), and then expands her turn to interpolate further details into her account (line 252; Stivers & Heritage, 2001). After a brief silence (line 253), Hung poses another question about eating that focuses on Tuyen's appetite (*ngon miệng*; line 254). His word choice, *ngon miệng* ('an appetite'), embodies his optimistic expectation about Tuyen's eating habits (Boyd & Heritage, 2006). Similar to the first question (line 248), this one, *ă:n ngon miê:ng không?* ('do you have an appetite?'; line 254), also constrains the answer to a 'yes' or 'no', yet Tuyen withholds these two tokens. She discloses her eating habits instead (line 255), which could be in response to Hung's cut-off talk at line 254, *ă:n được-* ('do you eat-'). Hung receives this information with a news marker, *hà:* ('oh'; line 257), which treats Tuyen's information as new, and two minimal tokens (lines 260-261) before changing tack to temperature preference (lines 263-264). He formats an alternative question composed of two TCUs, *hay là* ('or'; line 263), with two options *nóng* ('heat'; line 263) and *lạnh* ('cold'; line 264). The ordering of *nóng* ('heat') preceding *lạnh* ('cold') in this question may reflect the heat at the time of year in Vietnam when this recording was made (i.e., summer). In incorporating two options in two different TCUs, this question prefers the first option, *nóng* ('heat'), which is taken up by Tuyen with an example (lines 265, 269, 273, and 275). After several lines on this topic (lines 278-284), Hung moves to the new one: toilet habits (lines 286-287). He chains two questions in one turn (a general inquiry question, *đi ngoà:i đồ răng?* 'how about your toilet habits?', and an alternative one, *có bình thường không=hay là táo bó::n?* 'are they normal, or do you get constipated?'), separated by a micro pause only. Similarly, the positive words *bình thường* ('normal') precede the negative words *táo bón* ('constipated'), and so favour a no-problem response. Tuyen's response, *không* ('no'; line 289), conforms only to the action type of the second question. Hung's modified repeat (line 290) and *reversed polarity repetitional question* (Park, 2011; line 293) seek Tuyen's confirmation of her normal toileting habits, and close the sequence. In a reversed polarity repetitional question, doctors repeat their questions by reversing the polarity of the repeated turn right after patient's response (Park, 2011).

Extract 6.12 has illustrated how doctor medical questioning adheres to the principles of optimisation and recipient design. The first question (line 248) is

oriented to the demographic characteristic of Tuyen as an elderly patient, while the third (lines 263-264) displays his sensitivity to the fact that Tuyen may not be able to tolerate the current hot weather. The second (line 254) and the fourth questions (lines 286-287) are structured so as to convey a "best case" stance toward Tuyen's situation (Boyd & Heritage, 2006, p. 165). By and large, in his four questions, doctor Hung takes into account the "sensitivities to the medical and interactional exigencies" that are inherent in this situation (Heritage & Maynard, 2006a, p. 18).

A noteworthy point of this extract is the way patient Tuyen uses examples to insert the voice of the life-world as a substantiation for her temperature preference (lines 273 and 275). In addition to naming her choice, *NÓ:NG* ('hot'; line 265), Tuyen uses an example of 'staying in her room to avoid the heat' to illustrate this. In my data, examples are widely employed by patients to disclose various types of information. They are positioned either in response to the doctor's elicitor or as an expansion of their turn. Example-using practices include comparing the symptom with something serious (e.g., *hắn tê như cách hắn chết rồi a* 'my leg's numb as if it were dead') or providing examples of daily activities that make pain increase or reduce. For doctors, these practices offer insight into the problems themselves. They enable doctors to grasp the pain quality and its influence on the patient's lifestyle, evaluate the seriousness of the patient's condition more thoroughly, and make better diagnostic claims. For patients, these practices reflect the real-life difficulties that the pain has brought about. Hence, they express their concerns and desire for a therapy to alleviate the problem. This organisation of talk involves doctors in the patient's life-world, and thus creates what Barry, Stevenson, Britten, Barber, and Bradley (2001) term the *mutual life-world* in their discourse analysis study. Mutual life-world refers to the predominant use of the voice of the life-world by both doctors and patients.

Another notable point in this extract is doctor Hung's use of repeats of the patient's response in order to elicit information (lines 251, 267, and 290). These repeats lie in the third position after the patient's response (Schegloff, 1996), that is, at the third turn in a three-turn sequence: doctor's question, patient's response, and doctor's follow-up utterance (Coulthard & Ashby, 1976; Mishler, 1984; Todd, 1984). In my data, doctors adopt three forms of repeats: full repeat, partial repeat, and modified repeat. While full and partial repeats refer to an identical copy of the whole, or a part, of the previous utterance, a modified repeat keeps the same idea as

the previous utterance but its form has been changed to some extent (e.g., from question format to declarative format). Apart from the practice of repeating the same content, doctors also add prosody to the utterance in order to convey different communicative intents. Some doctors include other forms of agreement that precede or follow the repeat (e.g., line 259 in Extract 6.11).

In my data, doctor repeats have seven functions: (i) eliciting information, (ii) initiating repair, (iii) doing confirmation, (iv) registering receipt of prior turn, (v) displaying doctor's stance, (vi) holding the conversation floor, and (vii) directing a particular topical focus in conversation. The first two functions initiate a new sequence while the remaining ones do not initiate a new sequence, but close the sequence. The function of eliciting information can be subsumed in the broad function of 'targeting a next action', as identified by Schegloff (2007). This category means that doctors use the repeat practice so as to project the next action, which can be of different types. In my data set, however, the main function of targeting a next action is to obtain more information. Via repeats, doctors seek confirmation or disconfirmation of the patient's prior information. In return, they are able to obtain some more information from patients, or trigger the patient's repair of their information. While partial questioning or responding repeat aims to clarify a particular trouble in hearing, speaking, or understanding, initiate repair, invite the recipients to think again, and correct something in their prior utterance (Drew, 1992; Robinson, 2013), the doctors in this study adopt responding repeats in order to mostly check or confirm the patient's response. Overall, my data suggests that this mode of doctor repeat may be a distinctive feature of Vietnamese medical discourse.

While doctor Hung uses questioning and repeats, doctor Hai in Extract 6.13 uses the practice of assessment to elicit patient Ban's habits of doing exercise (lines 175-176). Similar to the doctor repeat strategy, this assessment strategy also falls in the third turn in a three-turn sequence. After doctors have received patients' answers, they sometimes utter an assessment in order to register their receipt of the information while also looking for further information. These assessments can be in the form of a question, a statement, an exclamation, or a positive comment. However, assessments as an elicitation strategy is just a candidate phenomenon (Hoey & Kendrick, 2018; Wong, 2000) in my data due to its limited instances. In Extract 6.13, Ban had arthritis in her shoulder, back, and leg, but her back has returned to 50% of normal thanks to previous treatment (data not shown). This

consultation thus only deals with her shoulder and leg. The following interaction is taken right before treatment recommendation.

```
Ex. 6.13: B 9 & 59
169 D:   rứ:a buổi sáng    dì   có  hay   đi tập thể+dục  KHÔ:NG?
   Hai   PRT  in  morning aunt PRT often go do  exercise  INT

         'Do you often do exercise in the morning?'

170      (0.2)

171 P:   buổi sá:ng   dì   đi  bơ::i
   Ban   in  morning aunt go  swim

         'I go swimming in the morning'

172      (0.5)

173 D:   sáng    đi bơ::i
   Hai   morning go swim

         'You go swimming in the morning'

174      (0.2)

175 D:→  đi   bơi  là  TỐT  rồi
   Hai   go   swim COP good PRT

176      [chi+nữa¿          ]
         INT

         'Swimming's good, isn't it'

177 P:   [đi   bơi  ni  hơn] #một# tháng rồi đây¿
   Ban   start swim now over one   month ago PRT

         'I started swimming over a month ago'

178      (.)

179 P:   khi+tê  là  đi  bộ  bừa   xe    là  bác+sĩ  noá:i  ri  là:::
   Ban   past    COP go  jog then  cycle COP doctor  say    PRT COP

180      (0.8) đạp-  à:: (.) đau+khớp  ni  đi::::::  (.) bộ  #không#
               cycle uh      arthritis this go           jog not

181      được bò  giừ:: (.) tập      qua:: (.) đi  bơi
         good so  now       exercise switch    go  swim

         'I used to go jogging and cycling, but the doctor said cycling-
         jogging was not good for my arthritis, so I've switched to
         swimming for exercise'

182      (0.3)

183 D:   ⌐hừ::::
   Hai   mmm

         'Mmm'

184 P:   sá:ng   mô   #cũng# đi  bơi  hết,
   Ban   morning every PRT    go  swim PRT

         'I go swimming every morning'

185      (1.2)

186 P:   đi  bơi  ni   hơn  #một# tháng rồi  đây,
   Ban   go  swim this over one   month PERF PRT
```

187

```
               'I've been swimming for over a month'

187     (0.4)

188 D:    bơi   hơn   #một#  tháng  rồ:::i?
   Hai    swim  over  one    month  PERF

          'You've been swimming for over a month?'

189 P:    °dẹ°
   Ban    yeah

          'Yeah'
```

At line 169, doctor Hai elicits Ban's exercise habits. He formats a 'yes/no' question using a pair of words, *có…không,* to demonstrate his lack of knowledge regarding the information he is requesting. However, with the embedding of the adverb of frequency *hay* ('often'), this question is optimised, which implies that Ban is likely to take morning exercise, but the frequency is unknown. Ban's answer, despite not conforming to the action type of the question, follows its topic agenda (line 171). Hai's uptake at lines 173 and 175-176 treats Ban's answer as relevant. This turn is composed of two TCUs. The first TCU, *sáng đi bơ::i* ('you go swimming in the morning'; line 173), is a modified repeat that registers his receipt of Ban's information. The second TCU, *đi bơi là TỐT rồi chi nữa¿* ('swimming's good, isn't it'; lines 175-176), is an assessment, which invites a discussion of Ban's exercise (Pomerantz, 1984c). In response to this assessment, Ban constructs a narrative of her exercise habits that includes: (i) duration of her exercise (lines 177 and 186), (ii) types of exercise (i.e., jogging, cycling, and swimming; lines 179-181), (iii) a previous expert's advice on her morning exercise routine (lines 179-181), and (iv) the frequency of her swimming (line 184). Through this narrative, Hai is able to obtain further information about Ban's daily life and especially the expert knowledge from her previous health provider.

Consider the assessment turn that doctor Hai structures to invite elaboration from Ban (lines 175-176). This turn is positioned after an adjacent pair about the frequency of Ban's swimming. Hai constructs this assessment as an expansion of his turn that receipts Ban's information. The assessment is in the format of a tag question, and ends with a question marker, *chi nữa* ('isn't it'), which embodies Hai's strong epistemic stance towards this assessment. In other words, Hai's assessment prefers agreement from Ban. Furthermore, the key word *TỐT* ('good') in the assessment turn is produced in a loud voice in order to capture Ban's attention. From

the medical perspective, Hai's assessment is institutionally relevant as a medical expert who provides advice to the health seeker. By airing this assessment, Hai not only supports Ban's swimming as a medical expert but also, through the tag-question structure, encourages Ban to disclose her health concern.

6.6.2 Medically-related activities

Medically-related activities include medication-taking. This information is important because it enables doctors to keep track of patients' adherence to medical treatment. In Extract 6.14, doctor Tuan wishes to know whether patient Tho takes his hypertension medication regularly or not (arrowed). This is because Tho has been suffering from seizures for more than one year, which are also his main concern for today's visit. In medical terms, severe uncontrolled hypertension may increase the risk of unprovoked seizure, as found in a quantitative study by Hesdorffer, Hauser, Annegers, and Rocca (1996).

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Ex. 6.14: A 2 & 14

67  D:→  lâu+ni huyết  áp        có-(0.2) mỗi  ngày có  uống một ˈviên không?
  Tuan    PROG   blood pressure PRT      per  day  PRT take one tablet INT

         'Have you been taking one tablet for blood pressure per day
         regularly?'

68  P:   dạ   có
  Tho    HON  yes

         'Yes'

69       (0.2)

70  D:   à:   =nhớ    uống (trước bữa) đều     vô  hây¿
  Tuan   mmm  remember take before meal regularly PRT INT

         'Mmm. Remember to take it regularly before meals'

71  P:   °dạ°
  Tho    yes

         'Yes'
```

At line 67, doctor Tuan uses an alternative question with the *có…không* format to determine the existence of Tho's medication-taking activity. He cuts himself off at the particle *có-*, pauses for 0.2 seconds, and then adds the words *mỗi ngày* ('per day') as a self-initiated repair. This self-initiated repair, together with the linguistic resources *lâu ni* (an indicator of progressive aspect) and *một viên* ('one tablet'), makes the question more detailed. These resources not only elicit the information requested, but also add emphasis to the importance of taking medication on a daily

basis and of adhering to a treatment regime. The whole question embodies Tuan's presupposition that, given his seizure problem, Tho must have taken hypertension medication for a long time. Tho's uptake, *dạ có* ('yes'; line 68), demonstrates his adherence to the treatment regime. Even so, Tuan registers his receipt of Tho's confirmation with a closing, *à:* ('mmm'; line 70), and then changes the topic (Gardner, 2001) to the re-affirmation of what Tho needs to do (line 70). This re-affirmation also acts as a reminder given that Tho's seizures may have resulted from his hypertension. Via this reminder, Tuan educates Tho on a good medication-taking habit, and strategically expresses the *educator voice* (Cordella, 2001, 2004) to inform Tho of his health condition. According to Cordella, doctors use the educator voice to educate patients about medical issues and to explain the results. Overall, in this sequence of talk, Tuan not only checks whether Tho has adhered to the treatment regime but also acts as a health educator.

6.6.3 Symptoms of other conditions

Apart from the main concern(s) for which patients seek doctor advice, patients may have symptoms of other conditions, which can be called mild ailments. Mild ailments may affect anyone, even a person when otherwise in good health. They include heartburn, nausea, belching, night sweats, or vertigo. Despite their mildness, these ailments may play an important part in a differential diagnosis, interfere with the doctor's treatment recommendation, and thus delay or reduce the effects of the medication to be taken. For this reason, a number of the participating doctors seek this information, as doctor Quy in Extract 6.15 below. Patient Ngoc has a contorted mouth and pounding in her right ear, but Quy is unable to find the cause of these symptoms after a long history-taking and physical examination (see Extract 6.6). Quy elicits three ailments: stomachache, heartburn, and chest discomfort (lines 363-364 and 381). This extract is taken near the end of physical examination.

```
Ex. 6.15: B 12 & 56
363 D:→  #trong#  bụng    là  hay   đa:u không? (.) hay   ợ+hơi
   Quy    inside  stomach COP often hurt  INT        often heartburn

364      ợ      [chua không?]
         belch acid   INT

         'Does  your   stomach  often  hurt?  Do  you  often  belch  or  have
         heartburn?'

365 P:          [dạ ↑không ]
  Ngoc          HON no
```

`No'

366   (5.6)

367 D: *vì::::::: à::::::: (.) mình phải   loại+trừ kí lí- (.)*
    Quy   because   uh   we   have+to rule+out CLA rea(son)

368   *NGUYÊN+NHÂN   chi   đó*
        cause   possible PRT

        `Because we have to rule out each possible cause'

369 P: *dạ*
 Ngoc   OK

        `OK'

370   (0.5)

371 D: *hắn nhiều cái nguyên+nhân mà   mình phải   loại+trừ (0.3)*
    Quy   it   many   CLA cause   which   we   have+to rule+out

        `There are many causes which we have to rule out'

372 D: *nguyên+nhân nếu+mà do   ma::: hay ghẻ::   hay+là::*
    Quy   cause   if   due+to ghost or   scabies or

373   *°vì   nguyên+nhân°*
        because   cause

        `such as ghosts[31], or scabies, or causes–'

374   (2.2)

375 D: *có   nhiều cái trường+hợp mà:::::: (.) mình phải*
    Quy   there+are many   CLA possibility so   we   must

376   *loại+trừ để   mình biết   cái nguyên+nhân mà trị+bệnh*
        rule+out so+that we   determine CLA cause   for treat

        **`There are many possibilities that we must rule out if we are to
        determine the cause, so that we can treat the problem'**

377   (25.4)

378 D: *bình+thườ::ng hây?*
    Quy   normal   INT

        `Was your condition normal before that?'

379 P: *dạ*
 Ngoc   yes

        `Yes'

380   (0.2)

381 D:→ *#không# mệt   ngực đồ   chi hây?*
    Quy   no   discomfort chest thing any INT

        `You don't have any chest discomfort or anything like that?'

382 P: *dạ (0.8) bì::nh+thườ::ng*
 Ngoc   yes   fine

        `No, I'm fine'

    Doctor Quy's first turn (lines 363-364) involves two successive questions

---

[31] Vietnamese people, especially those living in the rural areas, sometimes attribute pain to supernatural causes.

about stomachache, *trong <u>bụng</u> là hay đau không?* ('does your stomach often hurt?'), and heartburn, *hay ợ hơi ợ chua không?* ('do you often belch or have heartburn?'). They are separated by a micro pause (line 363) without giving Ngoc any opportunity to answer the first question. In both questions, Quy uses the adverb of frequency *hay* ('often'; line 363), which implies that the problem does occur, but its frequency is unknown. Although both questions target stomach problems, their trajectories and contents are not the same. The first question is rather general as it seeks to elicit any pain, *đa:u* ('hurt'; line 363), while the second is narrower in its scope, *ợ hơi ợ chua* ('[do you often] belch or have heartburn'; lines 363-364). In responding to this pair of questions, Ngoc formulates a disconfirmation (line 365) terminally overlapped with the final part of Quy's second question. Consequently, it is difficult to judge which question(s) this answer relates to. In this situation, Quy does not acknowledge this, but, after a lengthy silence of 5.6 seconds (line 366), moves to give a full explanation (lines 367-368, 371-373, and 375-376) for his two questions above (lines 363-364). Having finished his account, Quy leaves a long silence of 25.4 seconds (line 377; it is likely that he is continuing with the physical examination here) for Ngoc to take up the conversational floor. However, Ngoc does not respond. Such a long silence, together with a 2.2-second silence at line 374, is reflective of the fact that Ngoc does not follow what is being requested by Quy, as they are presented discursively as statements rather than questions. Quy then moves on to the topic of chest discomfort (line 381). He constructs this turn in the form of a declarative question polarised in a negative direction, which favours a 'no' response. Ngoc's brief and immediate response is aligned to that preference (line 382).

In Extract 6.15, doctor Quy's elicitors adhere to two fundamental principles in medical questioning. The first two questions in lines 363-364 are oriented to the assumption that certain problems (i.e., stomach problem, belching, or heartburn) have occurred. Given that the cause of Ngoc's issues has not been identified despite a long process of history-taking and physical examination, Quy's assumption is epistemically relevant. By asking these questions, Quy aligns with the principle of problem attentiveness. The third question, at line 381, presupposes the absence of any chest discomfort; that is, it embodies positive health outcomes. Hence, its preference for a 'no' response is optimised. Interactionally, Quy's design of this question comes from the normal condition disclosed by Ngoc in her prior turn. In other words, this question demonstrates an update in Quy's knowledge of Ngoc's

symptoms related to other conditions.

6.7 Past problems

Most of the patients in my data set have suffered from more than one problem before. At the doctor's office, they are asked to list all of them. Past problems may impact on the patient's current health (Tagney, 2008). In particular, this information enables doctors to select medication which is expected to work with the current problem (Wareing, 2003), but which will not trigger a recurrence of previous problems given that some medication can have side-effects that, depending on the problem, may cause previous problems to recur.

The doctors in this study employ different elicitation strategies to look for information about previous problems. They can elicit each problem separately using closed questions such as 'Have you had + [name of problem]?' (e.g., Extract 6.17). Alternatively, they can elicit all the patient's problems at the same time by using a summarisation plus a surveying question. A surveying question is used to scan the full range of patient concerns; for instance, questions such as 'Is there anything else that's bothering you?' seek to ensure that no concerns have been left unaddressed. For instance, in Extract 6.16, doctor Lam elicits Vu's unmet concerns and past problems using summarisation and surveying questions (all arrowed). Vu comes to this visit for multiple concerns related to his right shoulder, right elbow, and left kneecap. This extract is taken before the treatment stage.

```
Ex. 6.16: B 3 & 46

118 D:    rồ:i=ngoại+trừ   khớp     vai,   (0.8) vai     phải    nà:y
   Lam    well apart+from  arthritis shoulder    shoulder right   PRT

          'Well, apart from arthritis in your shoulder, your right shoulder'

119 P:    khuỷu+ta:y
   Vu     elbow

          'My elbow'

120 D:    khuỷu+tay phải    này (0.4)  khớp+gối  trái này
   Lam    elbow     right   PRT        kneecap   left PRT

          'your right elbow, and left kneecap'

121       (0.6)

122 D:→   ngoài+ra     anh            còn đau   chi        nữa  °#không#°?
   Lam    apart+from   older+brother  PRT bother anything  else INT

          'apart from this, is there anything else that's bothering you??'

123       (0.6)
```

```
124 D:    từ    trước  đến  chừ:?
   Lam    from   past   to   now

          'up to now?'

125       (0.7)

126 P:    có::  đau   cái  lung  là  nhiề:u ↑thôi¿ (0.4) trước+đây  có    lần
   Vu    have  pain  CLA  back  COP serious only         used+to   have  time

127       đau   trong  nội+tạng  là  đau  dạ+dày
          pain  inside innards   COP ache stomach

          'Only my back pain is serious. I used to suffer from pain in my
          innards, that's my stomachache'

128       (0.2)

129 D:→   à:: (.) >có  đau+dạ+dày< (0.2) anh           có:::::- (.)
   Lam    oh      have stomachache      older+brother PRT

130       mổ+miết  chi  không? (0.6) từ   trước #đến# chừ- (0.2)
          operation what INT         from past  to   now

131       từ    trước chừ có  mổ        chuyện chi khô:ng?
          from  past  now PRT operation problem any INT

          'Oh. You had stomachache. Did you have any operation? Have you
          ever had any operation?'

132       (0.3)

133 P:    °không°
   Vu    no

          'No'

134       (0.4)

135 D:    #không#  mổ       nơi  à?
   Lam    no       surgery  PRT  INT

          'No surgery?'

136 P:    từ    trước chừ chỉ:::  à::::  (0.5) ngoại+khoa  rứa+°thôi°,
   Vu    from  past  now just    uh           surgery     PRT

          'Just surgical problems³² until now'

137       (0.3)

138 D:    ngoạ:i+khoa?
   Lam    surgery

          'Surgical problems?'

139 P:    °dạ:°
   Vu    yes

          'Yes'

140       (0.2)

141 D:→   chưa-  chưa+một+lần  lên  bệnh+viện  Thống  Nhấ:t?
   Lam           never         to   hospital   Thong  Nhat

          'You've never been to Thong Nhat Hospital before?'
```

---

³² The patient uses the wrong medical term, *ngoại khoa* ('surgical problems'), when referring to non-surgical problems. To reflect what the patient actually said, I have kept the original meaning in the translation.

```
142       (0.6)

143 P:    không (.) không lên bệnh+viện=đều  nằm nơi
    Vu    no       not   to hospital  just go to

144       bệnh+viện cũ (.) Thanh Pho:ng  a
          hospital  old    Thanh Phong  PRT

          'No. I've never been to Thong Nhat Hospital. I've just been to an
          old hospital called Thanh Phong'
```

Doctor Lam uses the phrase *ngoại trừ* ('apart from'; line 118) to preface his summarisation of Vu's current concern, *khớp vai* ('arthritis in your shoulder'; line 118). Vu volunteers another concern, *khuỷu ta:y* ('elbow'; line 119), and Lam then adds to the list with one more concern, *khớp gối trái* ('left kneecap'; line 120). Lam pauses for 0.6 seconds (line 121) before projecting a surveying question to elicit any remaining problems from the past up to now (lines 122 and 124). Lam adopts the summarisation technique prefaced by the phrase *ngoại trừ* ('apart from'; line 118) to specify problems other than the ones listed thus far. The main question, *ngoài ra anh còn đau chi nữa ᵒ#không#ᵒ?* ('apart from this, is there anything else that's bothering you?'; line 122), is made after a 0.6-second pause (line 121), but unanswered after another 0.6-second pause (line 123), when Lam appends the time reference for clarification, *từ trước đến chừ:?* ('up to now?'; line 124), to broaden the scope of question. Without this addition, the question may elicit any unmet concerns only (Heritage & Robinson, 2011; Heritage et al., 2007) and exclude the past problems. Hence, the addition of a time reference to the past is important for eliciting specific information. This clarification makes Vu's next answer relevant (lines 126-127). He names two other problems, of which the first, *đau cái lưng* ('back pain'; line 126), refers to the most recent pain, while the second, *đau dạ dày* ('stomachache'; line 127), indicates a past ailment.

Based on Vu's answer, doctor Lam re-issues two more questions not related to Vu's stomachache (lines 129-131). Similar to his design of the two questions above (lines 122 and 124), Lam also adds a time reference to the second question, *từ trước chừ* ('ever'; lines 130-131). Receiving Vu's 'no' response (line 133), Lam then recycles the previous question at line 131 by using a reversed polarity question with the location markers, *lên bệnh viện Thống Nhất* ('to Thong Nhat Hospital'; line 141). This question obtains the information about Vu's past hospitalisation at a district hospital (lines 143-144).

The extract has shown doctor Lam's strategic deployment of his linguistic

resources in the course of seeking the information about Vu's unmet and previous problems. Three elicitors (all arrowed) move from general (i.e., the word *đau* 'bothering' in the first question at line 122 refers to any problems) to specific (i.e., the word *mổ* 'operation' in the second question at line 130 and the phrase *lên bệnh viện Thống Nhất* 'to Thong Nhat Hospital' in the third question at line 141, which covers any problems because Vietnamese patients often come to this national-level hospital when their problem becomes serious; see Section 4.1.1). Such orderly deployments of resources are strategic in their own right. While the first question (lines 122 and 124) sets the scene for the elicitation of unmet and previous problems, the second question (lines 129-131) arises out of the context where Vu only provides common ailments (i.e., *đau cái lưng* 'back pain', and *đau dạ dày* 'stomachache'; lines 126-127). This second question receives a disconfirmation (line 133) with an expansion as a justification (line 136), on which grounds Lam broadens his information-seeking act with the third question (line 141). By mentioning Thong Nhat Hospital, Lam orients to the serious problems only, which Vu may recall more easily. Despite its receipt of an aligned answer, *không* ('no'; line 143), this question is able to elicit further information about Vu's past problems (lines 143-144). Overall, three questions are constructed in the form of alternative questions, but their epistemic gradient is not the same. The first (lines 122-124) and second questions (lines 129-131), which contain the pairs of words *còn…không* and *có…không*, communicate weaker epistemics than those in the third question (line 141), where a declarative form is used. The third question is structured in pursuit of some specification of Vu's prior answer; thus, it is termed a *contingent question* (Boyd & Heritage, 2006). This question indicates that Lam's knowledge has been upgraded through locally interactional management as the consultation has developed.

By contrast, in response to the doctor's elicitation of past problems, patients elaborate on their responses (see Extract 5.13). This practice is used when patients anticipate doctors' questions about a certain issue, and thus pre-empt their elicitation by providing further information related to what has just been disclosed. Elaboration is often positioned as an expansion of the response turn, or occurs after doctor acknowledgement tokens (e.g., 'yes', 'mmm'). This practice is also commonly adopted in response to doctors' elicitation of recovery assessment, or past diagnoses and treatments. An example of patient's elaboration is presented in Extract 6.17, in which patient Dung pre-emptively elaborates on his response in order to save doctor

Tuan's further questions about his past problems (lines 45, 47, 49, 51, and 53). Dung has a herniated disc which was operated on in a different health centre seven years ago. He has now come to this hospital for long-term treatment of this problem.

```
Ex. 6.17: A 2 & 12
43  D:    trước+đây  có   đau+dạ+dày  không?
 Tuan    past        PRT  stomachache INT

          'Have you had stomachache in the past?'

44        (0.2)

45  P:    khô:ng
 Dung     no

          'No'

46        (.)

47  P:    #không#+⌈chi  hết¿
 Dung     nothing       at+all

          'Nothing at all'

48        (0.3)

49  P:    bình+thường
 Dung     fine

          'My stomach's fine'

50        (0.4)

51  P:    huyết  áp        bình+thườ:ng
 Dung     blood  pressure  fine

          'My blood pressure's fine'

52        (2.0)

53  P:    ngườ::i  là   bình+thường °thôi°
 Dung     body     COP  fine          all

          'My body's fine'
```

At line 43, doctor Tuan starts his elicitation of Dung's previous problems with a closed question about stomachache that sets up but does not force a 'yes' or 'no' response. Given that it presupposes the existence of stomachache, this is a problem attentiveness question. Dung gives a 'no' response (line 45) and, after a micro pause (line 46), adds *#không#* ⌈*chi hết¿* ('nothing at all'; line 47) for emphasis. Receiving no uptake from Tuan after a 0.3-second silence (line 48), Dung continues his turn by employing the adjective *bình thường* ('fine'; line 49) to describe the status of his stomach. This adjective, projected in a stressed fashion, aims to highlight the good condition of his stomach, in case the previous lexical items, *#không#* ⌈*chi hết¿* ('nothing at all'; line 47), failed to convey his intended meaning. Simply put, this

discourse action works to clarify his previous response in the face of no acknowledgement token from Tuan after two TRPs. Dung then transitions to the topic of his blood pressure (line 51), which also receives no uptake from Tuan after a lengthy silence of 2.0 seconds. Dung ends this sequence with an overall assessment of his body (line 53). The whole turn is constructed as an elaboration on the condition of his stomach, blood pressure, and body. Dung's response communicates that he has anticipated Tuan's next action, and so Dung discloses more to pre-empt this further questioning. Note also that even though Dung's expanding talk is topically different from Tuan's question, it is potentially relevant to Tuan's agenda of medical history elicitation. Another feature of Dung's response is that the organisation of information comes out of his experience gained from a previous clinical consultation, given that he has suffered from this pain for seven years and went to a hospital specialising in Western medicine (see Extract 6.8). In other words, through his previous consultation with another doctor, Dung has become accustomed to doctors' consulting styles and information-seeking activities.

In short, information of patients' past problems is sought using various techniques such as summarisation plus surveying question, *có…không* alternative question, or negative declarative question. Each question embodies different presuppositions about the patient's past problems, and is shaped by the doctor's epistemic stance. In turn, doctor epistemics are locally built up through moment-by-moment interaction with patients. Hence, as the consultation goes on, doctor elicitors are constructed differently to reflect the doctor epistemic gradient. The selective uses of these techniques are subject to the doctors' agendas and the patients' agendas. Similar to doctors, patients also deploy two disclosure practices: making a list or elaborating on their response. While a making-a-list practice is constrained by the doctor's elicitor, elaboration enables the patient to circumvent this constraint and volunteer more information.

6.8 Chapter conclusion

Chapter 6 has documented the information-seeking activities during history-taking and physical examination. Following Boyd and Heritage (2006), rather than a simple chain of elicitation and disclosure, history-taking and physical examination are organised within an overall set of activities comprising a set of sequences of action, each of which accomplishes a particular task. In line with previous research, the

doctors in this study also design their information-seeking activities as separate sequences that focus on two categories of doctor elicitation information: information about current problems, and information about the patient's medical history. In the course of seeking these categories of information, doctors deploy different elicitation types, such as questions, repeats of patient's response, fishing devices, examples, or assessments of patient's information, in order to elicit detailed or general information. Their elicitors are epistemically and interactionally structured in combination with linguistic selection (e.g., word choice), which in turn are aligned with the principles of problem attentiveness, recipient design, and optimisation, in medical questioning.

Apart from the information sought by doctors, patients sometimes expand beyond the agenda set by the questions to add further information. In particular, patients disclose five types of information: demonstrating their knowledge of the problem, disclosing minor problems, establishing the reasons for the visit, increasing the perceived severity of the problem, and making an assessment of the problem. Notably, these types of information are volunteered in the course of the patient's sequence expansion. Interactionally, patients deployed five practices to disclose the above information: (i) using examples, (ii) producing a narrative, (iii) invoking the opinion of a third party, (iv) elaborating on their response, and (v) making a list. These practices are not restrictive to a particular stage, a particular visit type, or disclosing a particular type of information. Rather, they are employed to disclose all information types throughout the consultations.

Chapter 7

Treatment and post-consultation

7.0 Introduction

Once the patient's chief problems have been identified and their relevant details have been fully obtained, the doctors proceed with the next stage of the consultation: the treatment recommendation. In the data set, the diagnosis phase is not discussed separately as it occasionally occurs during the elicitation of a past diagnosis and treatment (Section 6.5), or is integrated into the treatment recommendation (e.g., Extract 7.2). Chapter 7 is concerned with information about treatment options (Section 7.1) and information sought and disclosed through a prolongation of the consultation (Section 7.2).

7.1 Treatment options

The sequence of treatment recommendations occurs in the fifth phase of a medical visit (i.e., further treatment; Byrne & Long, 1976). These recommendations are offered on the basis of the information elicited during the consultation. It is generally believed that doctors do not seek any more information during this stage, and instead impart knowledge to patients by formulating treatment recommendation (Stivers, 2006). However, the doctors in this study also elicited patients' opinions of the recommended treatment prior to finalising their treatment decision. In turn, in addition to negotiating the treatment plan, the patients also disclosed different types of information about their problem.

7.1.1 Doctor elicitation

Two treatment recommendation practices have been identified: seeking the patient's confirmation that they agree to the treatment plan (Section 7.1.1.1), and offering multiple treatment options (Section 7.1.1.2).

7.1.1.1 Seeking the patient's agreement

In this approach, doctors pose a declarative question plus a rationale in a bid to obtain the patient's agreement with the treatment recommendation. This strategy is significant as once patients agree to a particular treatment plan, they are more likely

to comply with it (Burgoon, Birk, & Hall, 1991). There are three sequential patterns: (i) doctor's statement or informing act – patient's agreement, (ii) doctor's declarative question – patient's agreement, and (iii) doctor's declarative question – patient's resistance – doctor's rationale. The third format is exemplified in Extract 7.1 between doctor Vinh and inpatient Kieu. Vinh employs two questions ending with the particle *hây* to elicit Kieu's agreement with his treatment recommendation (lines 296-297 and 299). He proposes a specific treatment agenda by providing the names of the medication to be taken: *hoàn* ('tablets': line 297) and *thang* ('traditional medication'; line 299). The treatment is concerned with Kieu's spondylosis.

```
Ex. 7.1: B 7 & 64
296 D:→  giờ+chừ  mệ      vô          đây  mệ::::::::::::: (.)
 Vinh    now      grandma hospitalise here grandma

297      uố::::::::ng thuố::::::::::c (1.3)  HOÀN (.)  hây?
         take        medication             tablet    INT

         'Now, you take tablets while you're hospitalised, OK?'

298      (0.5)

299 D:   mấy ngày hoà:n rồi sau+đó ún   thút       thang    (.) hây?
 Vinh    PL  day  tablet and later take medication traditional   INT

         'You take tablets for the first few days and traditional
         medication later, OK?'

300      (0.3)

301 P:   °°dạ°°
 Kieu    OK

         'OK'

302      (0.5)

303 D:   chơ+còn  mệ      đau  dạ+dày ri       mà con      mà
 Vinh    because  grandma ache stomach like+this if offspring PRT

304      cho      mệ      uống thuốc  tây     là  mệ      đau
         prescribe grandma take medication western COP grandma ache

305      mệ      chịu  #không#+nổi  mô     (0.6) lhây
         grandma bear  not          at+all       PRT

         'Because you have a stomachache, the pain will become unbearable
         if I prescribe you Western medication'³³
```

In lines 296-297 and 299, doctor Vinh poses two questions in the same turn. The first question (lines 296-297) and the second question (line 299) are separated by a pause of 0.5 seconds (line 298) that passes the conversational floor to Kieu. The

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³³ My interpretation of Vinh's utterance is that, on top of the pain caused by her health problems, Kieu will have some additional pain if she takes Western medication for it. Hence, her total pain will become unbearable.

first part of the first question is stretched *mệ::::::::::::* ('you'), *uố::::::::ng thuố:::::::::c* ('[you] take [tablets]'), and followed by a pause of 1.3 seconds (line 297) right before the name of the medication, *HOÀN* ('tablets'). These linguistic resources indicate Vinh's difficulty in formulating the treatment recommendation. Without any verbal response from Kieu after 0.5 seconds (line 298), Vinh continues by posing one more declarative question (line 299) to supplement the first one; these two questions together constitute a complete treatment recommendation. In response, Kieu delays for 0.3 seconds (line 300), and then gives a whispered uptake (symbolised by double degree signs; line 301). Her whispered voice plus a 0.3-second silence most likely registers her passive resistance with Vinh's recommendation (Stivers, 2006). This puts Vinh in a position of working to convince Kieu to accept his proposed treatment recommendation. In fact, in lines 303-305, Vinh launches into an account of his decision using a compound TCU, *chơ còn … mà* ('because … if'). This next turn displays Vinh's orientation to Kieu's previous turn as a kind of resistance (Sidnell, 2012a).

In this extract, doctor Vinh offers his treatment recommendation in two ways: a recommendation for and against a particular treatment. These practices are also commonly adopted by doctors in Western culture (e.g., Stivers, 2005b, 2006). On the one hand, Vinh recommends the use of tablets and traditional medicine, but on the other he rules out the use of Western medication on the grounds that Kieu has a stomachache. The second practice is adopted as a means of backing up Vinh's first agenda. From an institutional perspective, his recommendation that Kieu use tablets and traditional medicine is relevant to the specialisation of the current hospital where traditional medicine is the principal treatment method. By and large, the whole sequence of treatment recommendation in this consultation aims to pursue Kieu's acceptance of Vinh's recommendation (Stivers, 2005b).

While the doctor in Extract 7.1 explicitly seeks the patient's agreement with his treatment plan, other doctors do this implicitly. They decide on a treatment plan for patients without overtly seeking the patient's prior agreement. In other words, they just move straight to the treatment recommendation as if it has been, or will be, agreed to by patients. This treatment strategy is also called *pronouncement* (Stivers & Barnes, 2017; Stivers et al., 2017). Sometimes doctors offer a rationale for their decision, as exemplified in Extract 7.2, but other times they do not. In Extract 7.2, doctor Hung directs patient Tuyen to take three tests: an X-ray for arthritis, a blood

test[34], and a gout test (lines 155-156, 159, and 167-169). Tuyen has hypertension, blood cholesterol, and an ankle problem, of which the ankle problem is the main concern.

```
Ex. 7.2: B 10 & 38

155 D:→  cho  mệ        chụp  cái  phim  lạ:i  để  xét+nghiệm  lại  (.)
    Hung  want grandma  have  CLA  X-ray again  to  check       again

156       ʃhi  (.)  xét+[nghiệm ]lại    cá:::i à::::::::::::
          PRT       check         again CLA   uh

          'I want you to have an X-ray again to re-check, re-check-'

157 P:                    [dạ     ]
Tuyen                      OK

          'OK'

158 P:    thử  máu
Tuyen     test blood

          'A blood test'

159 D:→   ʃkhó:p    (0.2)[coai] thử  [máu ]
    Hung  arthritis      see   test blood

160 P:                    [dạ  ]      [dạ d]ạ
Tuyen                       OK         OK  OK

          'OK. OK, OK'

161 D:    nhịn+đoá:i  (.) để  coai [thử    ]
    Hung  fast            to  see  PRT

          Lines 159 & 161: 'for arthritis, and you need to fast before you
          take the blood test to see if-'

162 P:                              [dạ:  dạ::]
Tuyen                                OK    OK

          'OK, OK'

163 D:    cái- à  (.) cá:i kiểm+tra #hắn# viêm+khớp hay+là
    Hung  CLA  uh  CLA  test     it    arthritis  or

          'it's arthritis or-'

164       (0.4)

165 P:    ừ
Tuyen     mmm

          'Mmm'

166       (0.2)

167 D:→   đợt    trưó::c  à::::::::::(0.5) #không#- #không# #không# biết đã
    Hung  visit  last     uh                        not            know PST

168       kiểm+tra gút  ʃchưa (.) đợt  ni   cho  mệ       kiểm+tra
          test     gout yet       time this want grandma test

169       thêm cái [gú::t  nữa.]
          also CLA  gout    PRT
```

---

[34] This is a general blood test, but the result can help to determine if the patient has arthritis.

```
                    'I don't know if you took a gout test on your last visit, so I
                    also want you to take a gout test this time'

170 P:              [dạ        ]  cho   cái gú::t  nữa
Tuyen               OK            want  CLA gout   too

                    'OK, I want a gout test too'
```

Of the three tests recommended by doctor Hung, the X-ray and the blood test are accompanied by a rationale (lines 155-156, 159, 161, and 163), but the gout test is not. By extending his treatment plan with accounts, Hung aims to get Tuyen to accept the treatment plan (Stivers, 2005c). The first TCU, *cho mệ chụp cái phim lạ:i để xét nghiệm lại (.)↗hi* ('I want you to have an X-ray again to re-check'; lines 155-156), ending with the final-rising-intoned particle *hi,* registers the whole TCU as a declarative question in pursuit of Tuyen's 'yes' response (Luu, 2010). Nevertheless, Hung produces further talk beyond the possible completion point *hi* and a micro-pause (line 156). Via this action, Hung orients to this declarative question as an informing act rather than a question, as there is no opportunity for Tuyen's response. Consequently, Hung's further talk on a rationale for the plan, *xét nghiệm lại cá:::i à::::::::::::* ('[to] re-check-'; line 156), leads to a *mid-turn progressional overlap onset* (Jefferson, 1984) with Tuyen's minimal acceptance, *dạ* ('OK'; line 157), of Hung's first recommendation. In a mid-turn progressional onset overlap, the next speaker (i.e., Tuyen) orients to the 'forward movement' of the current turn, and begins their talk at some point when the current speaker (i.e., Hung) is having trouble with progressing their turn toward completion. Tuyen then suggests another test, *thử máu* ('blood test'; line 158), which is agreed to by Hung in his next turn (line 159). Both the X-ray for arthritis and the blood test receive three instances of *dạ* ('OK'; line 160) successively, which communicates Tuyen's absolute agreement with Hung's treatment plan. Hung's mention of the blood test (line 159) is followed by an instruction, *nhịn đoái* ('you need to fast'; line 161), and then a rationale (lines 161 and 163). This instruction seems to be a final decision in response to Tuyen's suggestion at line 158. The recommendation of the last test, *gút* ('gout'; line 168), is prefaced with a retrospective review, *đợt trước không biết đã kiểm tra gút chưa* ('I don't know if you took a gout test on your last visit'; lines 167-168), without any rationale. It is also expressed as a statement rather than a question in which no negotiation is invited. In addition, there is no opportunity for Tuyen's response after the first TCU at the particle ↗*chưa* (line 168). One interpretation is that this design of

treatment recommendation communicates that Hung imposes the treatment on Tuyen.

Overall, doctor Hung neither gathers information about the problem nor explicitly seeks Tuyen's agreement with the treatment plan, although he receives it anyway with the 'OKs' in lines 157, 160, 162, and 170. Rather, Hung tends to state his final decisions according to his own agenda. In response, Tuyen displays alignment with Hung's treatment recommendation. The whole interaction, to some extent, suggests that Hung's strategy of treatment recommendation is acceptable to Tuyen.

Extracts 7.1 and 7.2 have shown how these doctors gain their patients' acceptance of their treatment recommendations by projecting questions or statements with which the patients give their agreement. These extracts also demonstrate how doctors sequentially set out their rationale in the local treatment negotiation to pursue the patient's acceptance. It is notable that this strategy is often used by doctors in the ward, where patients receive a two-or-three-week treatment course (see Section 4.1.3). As they have been examined by a doctor in the consulting room before being admitted to the ward, these patients necessarily approve of the treatment regime of this hospital. In this light, doctors in the ward tend to formulate their treatment recommendations as actions to be taken, rather than as proposals that need the acceptance of their patients. Overall, this pronouncement strategy may create a distinctive feature of Vietnamese medical consultations, which differs from the Western medicine where this strategy is commonly adopted in primary care visits (i.e., in the consulting room; Stivers et al., 2017). Although some patients respond with resistance and others do not, their involvement in the treatment decision is quite limited (i.e., they do not raise their opinion on the treatment recommendation). However, this is not true of all the patients in this study (see Section 7.1.2). In what follows, I will show how doctors offer multiple treatment options to involve patients in the negotiation of treatment plan.

7.1.1.2 Offering multiple treatment options

Besides seeking the patient's agreement with the treatment recommendation, doctors offer patients one or more options for treatment to choose from. In the data set, doctors in the consulting room offer multiple treatment options more often than doctors in the ward. However, this strategy is considered as a candidate phenomenon

in my data as its instances are more limited than those of the previous strategy. There are two sequential patterns of this strategy: (i) doctors name first treatment method – doctors ask if patients also want to combine the first method with another method – patient agrees or disagrees; and (ii) doctors ask patients to select one treatment method from two available options – patients select one. This strategy is labelled as *offers* (Stivers et al., 2017), which treat patients as a decision-maker. Offering multiple treatment options means involving patients in the treatment decision, which, in turn, may increase the patient's satisfaction (Street, Cox, Kallen, & Suarez-Almazor, 2012) and improve the treatment outcome and the patient's physical and mental health (Brody, Miller, Lerman, Smith, & Caputo, 1989; Kaplan, Greenfield, & Ware, 1989). This strategy is endorsed by many health policy researchers (Butler, Rollnick, Pill, Maggs-Rapport, & Stott, 1998; Emanuel & Emanuel, 1992), as treatment decisions are the shared responsibility of both doctors and patients (Stivers, 2006).

In Extract 7.3, doctor Quynh offers two choices to patient Phong (arrowed), from which Phong is to select one. Phong has pain in her arm running up to her shoulder, and this is her first visit to the consulting room.

```
Ex. 7.3: B 1 & 9
184 D:   giờ+chừ::::::::::::::::::: à::: (.)  lần  ni   chị
  Quynh  so                        uh        time this older+sister

185      vô:::::::::: (0.2)  châm+cúu?
         come               acupuncture

         'So, you've come here for acupuncture?'

186 P:   dạ::
  Phong  yes

         'Yes'

187      (0.4)

188 D:→  nằm+viện    ở+lại     hay+là chị         muốn vừa  đi
  Quynh  hospitalise inpatient or     older+sister like half hospitalise

189      [vừa    ]  v[ề ]?
         half       home

         'Would you like to have inpatient, or outpatient treatment?'

190 P:   [thì:::::]  [cô]  cho       em          ở+lại     thì
  Phong   PRT         doctor prescribe older+sister inpatient COP

191      em              ở+lại
         younger+sister  inpatient

         'I'll have inpatient treatment if you prescribe it'

192      (.)
```

```
193 P:   còn    về   thì hắn quá  khổ          a+đó:¿
  Phong  about  home  COP it  very troublesome PRT

         'If you don't, outpatient treatment will be very troublesome for
         me'

194      (1.1)

195 D:   °dạ° (.) rứa+thì: nằm+việ:n  ở+lại    nghe?
  Quynh  OK       so      hospitalise inpatient INT

         'OK. So, you'll have inpatient treatment?'

196      (0.2)

197 P:   dạ:
  Phong  yes

         'Yes'
```

   As described in Section 4.1.3, the main duty of the doctors in the consulting room is to categorise patients as consulting patients, inpatients, or outpatients. This activity is often carried out in the treatment phase, as doctor Quynh in this extract does in lines 188-189. Quynh prefaces her treatment recommendation with a declarative question in lines 184-185 to seek Phong's confirmation of an agreed treatment recommendation (data not shown), _châm cứu_ ('acupuncture'; line 185). Although Phong has already agreed to use this treatment method, Quynh emphasises this method when she recalls it, _châm cứu_ ('acupuncture'). In other words, her interactional action works to set the agenda for her upcoming treatment recommendation. Having received Phong's confirmation (line 186), Quynh proposes a two-option alternative question, _nằm viện ở lại_ ('inpatient'; line 188) or _vừa đi vừa về_ ('outpatient'; lines 188-189). She uses the word _muốn_ ('like') in order to pose her question as an offer. In response, Phong's early start (line 190) engenders a terminal overlap with Quynh's last two words, but does not create a mishearing or misunderstanding for either speaker. At first glance, the first TCU _cô cho em ở lại thì em ở lại_ ('I'll have inpatient treatment if you prescribe it'; lines 190-191) hands the treatment decision responsibility back to Quynh, but the second TCU _còn về thì hắn quá khổ a đó_ ('if you don't, outpatient treatment will be very troublesome for me'; line 193) is oriented to the first option, _nằm viện ở lại_ ('inpatient … treatment'; line 188). In other words, Phong's interactional strategy limits Quynh's decision by excluding the outpatient option. By designing her turn in this contrasting fashion, Phong on the one hand positions herself as a passive recipient who is willing to adhere to the doctor's treatment recommendation, but on the other expresses her preference for inpatient treatment.

To recap, Section 7.1.1 delineates two practices that the doctors implement to recommend a treatment plan: seeking the patient's agreement with the treatment recommendation, and offering multiple treatment options for the patients to choose from. While the former strategy is often adopted by doctors in the ward, the latter is commonly used by doctors in the consulting room. Thus, the doctors' choice of technique indexes their strategic management of the consultation agenda in accordance with each visit type and visit location. This choice is constrained by the institutional context of Vietnamese public hospitals.

7.1.2 Patient decision-making

The patient's decision-making is shaped by the doctor's agenda for elicitation. On receipt of the doctor's treatment recommendation, some patients express their acceptance of the recommendation (e.g., Extract 7.2), while others deploy three practices: resisting the doctor's agenda (Section 7.1.2.1), negotiating the treatment plan (Section 7.1.2.2), or suggesting a course of treatment (Section 7.1.2.3). In adopting these practices, patients index their epistemic stances towards their medical history as well as their treatment preferences.

7.1.2.1 Resisting the doctor's agenda

According to Stivers (2006), there are two types of patient resistance to the doctor's proposed treatment recommendation: passive resistance and active resistance. Although active resistance is stronger than passive resistance, both put the doctor in the place where they must initiate a new sequence to secure acceptance from the patient. In this study, passive resistance is delivered in the form of a *dạ* ('yes', 'OK', or 'yeah') token in a quiet manner or with a low pitch, in response to doctor's treatment recommendation (see Extract 7.1). *Dạ* ('yes', 'OK', or 'yeah') in this case indicates the patient's respect for, rather than their willingness to comply with, the doctor's recommendation (see Section 2.3.3.3). To show their active resistance, patients reject doctor's recommendation overtly by invoking the opinion of a third party, mentioning life difficulties that prevent them from following that treatment plan, or suggesting another option instead. Extract 7.4 below shows how active resistance is done by patient Hanh in response to doctor Nam's recommendation that she should have more exercise. Hanh tries to justify her projected non-adherence to Nam's treatment recommendation by invoking a third party. Hanh has pain in her

shoulder and ribs and this is her DDF. This extract is sequentially organised following the three-step format of advice-giving observed by Heritage and Sefi (1992): Nam's *initial inquiry* (lines 253-258) – Hanh's *problem-indicative response* (lines 261-267) – Nam's *advice-giving* (lines 268-271).


```
Ex. 7.4: A 1 & 3
253 D:   mệ      cố+gắng vào        đây   vận+động
  Nam    grandma should  hospitalise here exercise

         'You should get some exercise during your hospitalisation'

254      (0.8)

255 P:   dạ=
  Hanh   yeah

         'Yeah'

256 D:   =đi+lại   nhiều+vô #một# chút  ⌈nữ:a,
  Nam    walk      much     a     little more

         'Walk a little more'

257      (0.4)

258 P:   dạ:
  Hanh   yeah

         'Yeah'

259      (0.3)

260 D:   đó::: (0.2) [ngoài  cái-  cá:::i-]
  Nam    that        except        CLA

         'That's it. Except-'

261 P:               [hôm bữa      tui đi] tậ:p     mà::::::::::::::::::
  Hanh               day last      I   have exercise but

262      (0.5) bác+sĩ #không# cho:, (0.2) ồ:: (.) ⌈cú::    (0.2) đi
               doctor not     allow           uh       whenever       go

263      tập      là về:: là:::: (.) nê::n (0.5) một trăm    SÁU   luô:n¿
         exercise COP home COP            go+up      one hundred sixty PRT

         'In my last hospitalisation, the doctor didn't allow me to have
         any exercise. My blood pressure went up to one hundred and sixty
         whenever I exercised'

264      (0.9)

265 D:   à:::::::: (.) rúa+ha?
  Nam    oh           really

         'Oh, really?'

266      (0.2)

267 P:   dạ:: (.) ĐI:: TẬP       là về là  trăm        [sáu¿]
  Hanh   yes      go  exercise  COP home COP one+hundred sixty

         'Yes. It went up to one hundred and sixty whenever I exercised'

268 D:                                                 [thì ] mệ
  Nam                                                  then   grandma
```

209

```
269      uống  thuốc     đi:, (.) uống thuốc    trước+khi::: à::::::::::
         take medication PRT     take medication before        uh
270      (0.2) tập    (0.6) rồi  về::=rồi  mà  đi  vận+động (.)
               exercise      PRT  home then COP walk exercise
271      #trong#+[nhà+#trong#+cửa]
         indoors
```

'In that case, you should take some medication before you
exercise, and walk around indoors at home'

At line 253, doctor Nam employs a verb of obligation, *cố gắng* ('should'), to advise Hanh to get some exercise while in hospital. After a delay of 0.8 seconds (line 254), Hanh responds with a minimal uptake, *dạ* ('yeah'; line 255). Nam immediately adds further advice on walking (line 256), which is also receipted with a minimal uptake, *dạ:* ('yeah'; line 258), after a 0.4-second silence (line 257). Projected in delayed fashion (lines 254 and 257), Hanh's two minimal uptakes, *dạ* ('yeah'; lines 255 and 258), signal her passive resistance to Nam's advice (Stivers, 2006). *Dạ* ('yeah') in these cases aims to indicate Hanh's attentiveness to Nam rather than show her agreement with what he is actually advising. Nam's further talk (which is probably more advice) at line 260 is oriented to Hanh's use of *dạ* ('yeah') as resistance, but he cuts it off because it overlaps with Hanh's account of her projected non-adherence (lines 261-263). Within this talk about her last treatment course (lines 261-263), Hanh pauses several times in order to preface her disagreement (Pomerantz, 1984a). To bolster her claim, Hanh not only invokes the professional voice of her previous doctor, *bác sĩ không cho* ('the doctor didn't allow me to have any exercise'; line 262), but also cites an example of hypertension, *nên một trăm sáu* ('my blood pressure went up to one hundred and sixty'; line 263). Hanh's active resistance puts Nam in the position of having to justify his proposed treatment recommendation (Stivers, 2006). After 0.9 seconds (line 264), Nam receives Hanh's information with a *news receipt* (Jefferson, 1981; Maynard, 1997) in the form of a stretched change-of-state token, *à::::::::* ('oh') plus *rứa ha?* ('really?'). This is a common type of non-minimal post expansion (line 265). Both linguistic devices treat Hanh's information as news, or as worthy of comment, and invite possible elaboration or qualification (Maynard, 2003; Stivers, 2012). Given the floor, Hanh continues with a modified repeat of her prior turn to emphasise how high her blood pressure was when she exercised (Rabab'ah & Abuseileek, 2012; line 267). In response, Nam passes on further advice on taking medication, reaffirms his previous recommendation, *uống thuốc trước khi tập* ('[you should] take some medication

before you exercise'; lines 269-270), and extends it to walk around indoors at home (lines 270-271). This is all consistent with treating Hanh's utterances as resistance.

There are four implications of Hanh's resistance. First of all, the claim, *hôm bữa tui đi tập mà bác sĩ không cho* ('in my last hospitalisation, the doctor didn't allow me to have any exercise'; lines 261-262), reveals that she is aware that exercise is important for her health, and that she used to have it. Second, through addressing a past event, Hanh implies that she is resisting this advice. Third, she is signalling why it would be difficult for her to act on this advice, which places pressure on Nam's expert knowledge. Lastly, by resisting Nam's advice to take exercise, Hanh wants to discount this option.

In Extract 7.4, patient Hanh invokes the opinion of her previous doctor to bolster her claim that she should not exercise (lines 261-263). In my data, the practice of invoking a third party is prevalent (e.g., Extracts 5.14 and 6.4). This practice has its own benefit in that the patient's claim is validated or sanctioned by another person, thus reducing their own agency and accountability in the matter (Heritage & Robinson, 2006a). The third parties invoked can be either professional (e.g., referring doctors) or non-professional (e.g., outsiders). Also, patients sometimes invoke relatives who are health professionals working either in the current hospital, or in other health centres known to doctors. In my corpus, few doctors invoke the patient's relatives as third parties for the sake of their own agendas, rather, it is patients themselves who do this, reflecting Vietnamese cultural features. In a relationship-based and hierarchical country like Vietnam (Edwards & Phan, 2013; T. Q. N. Trần, 2013), it is reasonable to assume that having a relative or acquaintance working in the same institution will be advantageous for receiving better care and treatment. However, this does not mean that other patients are not given good care. Rather, based on their relationship, the relatives can give advice on the best treatment method, or recommend an experienced doctor on their first visit.

While patient Hanh resists Nam's treatment plan with her non-alignment, patient Luong in Extract 7.5 explicitly rejects her doctor's treatment recommendation. This is shown in lines 295, 297, 301, and 322-323, in which Luong resists Quynh's recommendation that she should take acupuncture. This resistance is prefaced by Luong's *blocking response* (Schegloff, 2007) at line 295 to Quynh's pre-recommendation (lines 291-292). A blocking response is a negative response to a request, which means that the precondition for the request is not satisfied. Luong has

had pain in her back down to her kneecaps for over ten years. During this period, she has had her kneecaps X-rayed and treated at other health centres several times.

Ex. 7.5: B 1 & 11

```
111 D:   có   khi+mô   CHÂM+cúu   uống thuốc   Bắc     không?
   Quynh  PRT  ever     acupuncture have medicine Chinese INT

         'Have you ever had acupuncture together with Chinese medicinal
         herbs?'

112      (0.2)

113 P:   khô:ng (0.5)  thuốc   ⌐Bắ:c   là  qua mua Thọ Xuân Đường
   Luong  no           medicine Chinese COP go  buy Tho Xuan Duong

         'No. I bought Chinese medicinal herbs at Tho Xuan Duong'

114 D:   à    mu:a Thọ Xuân Đường, (.)  là   uố:ng      thôi chợ+đâu có
   Quynh  oh   buy  Tho Xuan Duong       COP medication only not       have

115      châm        hây?
         acupuncture INT

         'Oh, you bought some medication at Tho Xuan Duong. So you've only
         had Chinese medicinal herbs, not acupuncture?'

116 P:   không  (.)  uố:ng       thôi
   Luong  no          medication  only

         'No. Chinese medicinal herbs only'

117      (0.3)

118 D:   rồ:::i  (.) [dạ          ]
   Quynh  OK          OK

         'OK. OK'

119 P:               [#không# châm]
   Luong              no       acupuncture

         'No acupuncture'

120      (0.2)

121 D:   [dạ: rồ::i ]
   Quynh  HON  OK

         'OK'

122 P:   [nói tóm+lại] là  châm        mà  sợ       #không# châm       (0.3)
   Luong  say  briefly COP acupuncture COP worried not      acupuncture

123      châm        là a-  sợ     á:p      huyế:t #hắn# lê:n
         acupuncture COP uh  worried pressure blood   it    high

         'I just don't like acupuncture. I'm worried that it might cause
         high blood pressure'

         ((108 lines deleted))

231 P:   bựa #con# Lan vẹ  qua châm        mà  có  qua mộ¿
   Luong  day Ms    Lan tell come acupuncture but PRT go  not

         'A few days ago, Lan told me to come to her house for acupuncture,
         but I didn't go'

232      (1.1)
```

212

```
233 D:    dạ
   Quynh  OK

          'OK'

          ((58 lines deleted))

291 D:    có    điều+kiện  để+mà  vô    đâ::y  châm        =từ  Mai
   Quynh  have  can        to     come  here   acupuncture from Mai

292       Dịch [vô  ] đây  xa   không?
          Dich to       here far  INT

          'Can you come here for acupuncture? Is it far from here to Mai
          Dich?'

293 P:         [không ]
   Luong        no

          'No'³⁵

294       (0.5)

295 P:    đừng  châm        nũ:a
   Luong  no    acupuncture PRT

          'No acupuncture'

296       (0.7)

297 P:    kê:::       mà   mua  thuốc      uố:ng thôi¿
   Luong  prescribe   to   buy  medication take  just

          'Just prescribe me some medication'

298       (0.2)

299 D:    mu:::a (.) thút        ún   thôi hậy?
   Quynh  buy       medication  take just INT

          'Just medication?'

300       (0.3)

301 P:    đi mua thuốc      uống [thôi chơ:::] không [châm]
   Luong  go buy medication take  just but      no   acupuncture

          'No acupuncture. Just medication'

302 D:                            [nế::u+như::]     [ngoài] Ai  Dịch có
   Quynh                           if               in     Mai Dich have

303       trạm  y+tế:  gần  a¿ (0.4) chị        chịu+khó qua đó   #hắn#
          station medical near PRT    older+sister try      go  there they

304       châ:m        kết+hợp đi¿ (0.5) thì vừa  châm+cứu     vừa
          acupuncture  together PRT      COP both acupuncture and

305       thuốc  Bắc      #cho# [mau   lành  ]
          medicine Chinese for    quick better

          'If you live near a medical station in Mai Dich, try going there
          for acupuncture together with Chinese medicinal herbs, and you'll
          get better quickly'

306 P:                            [trạ:m #hắn#] cần  i+nầy (0.2) dà:  mô
   Luong                           station it   near PRT        house PRT

307       tụ:::(.) sau    nương   trước+mặt dà::  a+nì
          at       behind backyard in+front house PRT
```

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³⁵ Due to the overlapping talk in lines 292 and 293, this utterance is a response to only the first
question, *có điều kiện để mà vô đâ::y châm* ('Can you come here for acupuncture?; line 291).

'It's quite near, behind my backyard- in front of my house'

308   (0.9)

309 P: dà::   #con# La:n a¿
  Luong   house   Ms   Lan   PRT

         'That's Lan's house'

310   (0.4)

311 D: dạ::
  Quynh   OK

         'OK'

312   (0.2)

313 P: ầ:::
  Luong   mmm

         'Mmm'

314   (0.3)

315 D: tức+là cái chị   Lan làm ở   đây là ở   gần
  Quynh   mean   PRT older+sister Lan work in   here COP live near

316   chị   phải+KHÔNG?=
         older+sister INT

         'You mean, Lan who works here lives near you. Is that right?'

317 P: =GẦ:N (.) cả   hai mẹ   con   gần nhau   luôn+đây
  Luong   near   both two mother offspring near each+other PRT

         'Yes. We two live near each other'

318 D: rứ::a+thì::: nhờ: chị   ⌈La:n (.) hây?
  Quynh   so   ask older+sister Lan   INT

         'So how about asking Lan?'

319   (0.2)

320 P: [nhờ La:::n được   ]
  Luong   ask Lan   can

         'I can ask Lan'

321 D: [nhờ chị   La:n chị::]   châm   thêm
  Quynh   ask older+sister Lan older+sister acuphuncture combine

         'Ask Lan to do acupuncture for you?'

322 P: mà   chừ::::::: (.)   mua- mua- mua=mua thuố:c   uố:ng
  Luong   but   now   buy medication also

323   #cũng# đượ::c
         take   enough

         'But medication is enough'

324   (0.3)

325 D: dạ:::
  Quynh   OK

         'OK'

        In the first sequence about Luong's previous treatment for her legs (lines 111-

214

121), doctor Quynh asks if Luong's leg pain has ever been treated with acupuncture along with Chinese medicinal herbs (line 111). This elicitation displays Quynh's orientation to the recommendation of acupuncture and Chinese medicinal herbs to Luong's problem. Anticipating Quynh's agenda, Luong rejects the option of acupuncture on the grounds that she thinks it may cause high blood pressure (lines 122-123). Luong's account displays her lay knowledge of the problem, which may have been acquired from her long experience of this problem, or from previous treatment courses at other health centres. After 108 lines concerned with Luong's problems with her back and her blood pressure (data not shown), Luong rejects the acupuncture option again, this time invoking the third party, Lan, to support her rejection (line 231). Lan is an acupuncturist working in this hospital who also happens to be her daughter. Luong's use of the recognitional form (i.e., personal name) implies that the referent is known to Quynh at this point. In associating the acupuncture option with another medical professional who is her daughter, Luong is able to use her familial relationship with Lan to forestall Quynh's preferred treatment agenda and, ultimately, supplant it with her own. Quynh treats Luong's invocation of Lan as a form of resistance. In delayed fashion of 1.1 seconds (line 232), Quynh shows her disaffiliation through a weak token, *dạ* ('OK; line 233).

As the consultation develops, Quynh gets back to her previous agenda by recommending acupuncture (in combination with Chinese medicinal herbs) overtly for the third time (lines 291-292), and Luong continues to actively resist the acupuncture treatment option (line 293). After two silences (lines 294 and 296), Luong rejects Quynh's treatment option with a blocking response (line 295) that seeks to prevent Quynh from issuing her recommendation (Schegloff, 2007), and requests an alternative, *mua thuốc uống* ('some medication'; line 297). Once again, Luong reaffirms her treatment preference (line 301) in her response to Quynh's request-for-confirmation question (line 299). Despite this resistance, Quynh is sticking to her treatment recommendation (lines 302-305). Given Luong's difficulties in travelling to this hospital (lines 302-304) for acupuncture on a daily basis (Luong lives in a village which is quite far from this hospital), Quynh recommends that Luong have this type of treatment at a village hospital in her community, in combination with Chinese medicinal herbs (lines 302-305). In response, Luong mentions the location of the village hospital (lines 306-307 and 309), which triggers Quynh's two questions: one (lines 315-316) seeking Luong's confirmation (line 317)

and one (line 318) acting as a recommendation. Luong engages in Quynh's second question using a *pro forma agreement* format (Schegloff, 2007), *nhờ Lan được* ('I can ask Lan'; line 320), as if to suggest that she will act on Quynh's recommendation. A pro forma agreement format means the speaker initially commits to the future course of action but later shows their disagreement. In fact, Luong quickly reverts to her initial position (lines 322-323).

Extract 7.5 has indicated how patient Luong actively resists Quynh's treatment recommendation by explicitly rejecting acupuncture. In general terms, the fact that Quynh gives up her treatment recommendation and follows Luong's treatment preference represents a suppression of the expert voice (i.e., Quynh's treatment recommendation) by the lay voice (i.e., Luong's treatment preference). At the same time, Quynh's concession is problematic from a medical perspective (Stivers, 2006). In taking this step, she puts the final treatment decision in the hands of Luong on the basis that her health is her own responsibility: as a health provider, Quynh's role is only to give her advice, and not to impose her own treatment agenda on Luong. This step necessarily also has the effect of diminishing Quynh's accountability for any problems that might result from Luong's future treatment.

7.1.2.2 Negotiating the treatment plan

In negotiating the overall treatment plan, patients have reached an agreement with doctors regarding this plan. Even so, they may wish to negotiate parts of it before doctors finalise it. The patients in this study negotiate with their doctors about various issues related to their treatment, ranging from prescriptions, and the choice between inpatient and outpatient treatment, to the selection of the attending nurse. Via negotiation, they voice their desire for a particular kind of treatment, the involvement of a certain health professional, or the amount of medication to be purchased. Negotiation about the prescription is illustrated in Extract 7.6. Patient Mi, who lives quite far from the current hospital, has come to see doctor Hoang for treatment for her depression. This extract is taken near the end of the consultation when Hoang and Mi have agreed to the prescription of Chinese medicinal herbs (data not shown). In this extract, Hoang makes a proposal (Stivers & Barnes, 2017; Stivers et al., 2017) that he prescribe ten packs of medicine (line 122) but Mi negotiates for five packs only (lines 125-126).

```
113 D:    chừ /bác    kê      cho con        khoả:ng à::::(2.0) /năm  thang
 Hoang    now doctor prescribe for offspring about  uh          five  pack

          'Now, I'll prescribe about five packs of medication for you'

114 P:    dạ:
   Mi     OK

          'OK'

115       (0.3)

116 D:    /uống coi+thử răng rồi rồi (.) /tiếp   (.) hêy?=
 Hoang    try   see     how  then      continue    INT

          'Try them and see how they work, and then you can buy more, OK?'

117 P:    =dạ
   Mi     OK

          'OK'

118       (0.9)

119 D:    năm hay /mười thang? (.) ở    mô?  (.) [gần] đây [không]?
 Hoang    five or ten    pack       live where     near here INT

          'Five or ten packs? Where do you live? Near here?'

120 P:                                          [dạ:]      [Tràng] /An
   Mi                                           HON        Trang    An

          'Trang An'

121       (1.1)

122 D:    Tràng An /chắc   #cũng# mười gói: như /rúa a+chơ (.)
 Hoang    Trang An probably PRT   ten  pack like that PRT

123       >xa quá¿<
          far very

          'You probably need ten packs, as Trang An is very far from here'

124       (1.4)

125 P:    cho        #con#   năm /thang #cũng# được=rồi ki- rồi  co-
   Mi     prescribe offspring five pack  only  can then      then

126       con    /lên lại  cũng được=bởi+vì con     [hay  lên] Vinh a
          offspring come again also PRT as   offspring often come Vinh PRT

          'Please prescribe five packs only, and then I'll come back for
          more, as I often come to Vinh'

127 D:                                              [ừ:::    ]
 Hoang                                              mmm

          'Mmm'

128 D:    (là) hay hay /lên thường+xuyên phải+không?=
 Hoang    COP      often come often         INT

          'You often come here, don't you?'

129 P:    =dạ
   Mi     yes

          'Yes'
```

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At line 113, doctor Hoang informs Mi that he intends to prescribe about five packs of medication. Of note is that the number of packs, *ˈnăm thang* ('five packs of medication'), is delivered after 2.0 seconds, prefaced by a proximator, *khoả:ng* ('about'), and an elongated pause-filler, *à:::* ('uh' in the gloss'). These discursive and interactional resources foreshadow a change of plan later. Mi's agreement, *dạ:* ('OK'; line 114), occasions Hoang's further elaboration on his treatment recommendation (line 116). In this elaborating turn, Hoang suggests that Mi can buy more packs once these five packs have been used up, *rồi ˈtiếp* ('and then you can buy more'; line 116). Mi immediately agrees to Hoang's plan (symbolised by equal signs '='; lines 116-117). Although both participants have reached an agreed plan, after 0.9 seconds of silence (line 118), Hoang projects an alternative question to add one more option to his previous plan: *năm hay ˈmười thang?* ('five or ten packs?'; line 119). He then elicits Mi's location, *ở mô? gần đây không?* ('where do you live? near here?'; line 119), as a preface to his justification for changing the plan. On receipt of Mi's information, *Tràng ˈAn* ('Trang An'; line 120), Hoang pauses for 1.1 seconds (line 121) before coming to his decision, *ˈchắc #cũng# mười gói:* ('[you] probably need ten packs'; line 122). He uses the hedge device, *ˈchắc* ('probably'; line 122), to treat his new plan as tentative, which calls for Mi's acceptance. Hoang ends this turn with a justification for his updated decision, *xa quá¿* ('very far from here'; line 123). Mi delays her answer for 1.4 seconds (line 124), thereby foreshowing a dispreferred response (Levinson, 1983). She then suggests purchasing five packs, not the ten as suggested (line 125). Her suggestion (lines 125-126) is delivered in a mitigated form by invoking contingent knowledge of her own circumstances (Heritage, 1984c). Via raising this account as a *subject-actor* (Pomerantz, 1980), Mi is able to head off further options from Hoang.

Extract 7.6 has illustrated how patient Mi interactionally and linguistically organises her overall sequence of talk to negotiate the amount of medication to be purchased. At the beginning of the sequence, Mi, without any delay, expresses her agreement with Hoang's proposal that she take five packs of medication (line 114). Likewise, Mi agrees immediately after Hoang ends his elaboration turn at line 116. In other words, her immediate agreement indicates that five packs is the appropriate amount at this stage. Therefore, when Hoang proposes that she take ten packs, Mi deploys a delay plus an account in order to negotiate for five packs of medication rather than ten. Overall, through her interactional deployment, Mi succeeds in

receiving the number of packs that she prefers.

7.1.2.3 Suggesting a course of treatment

By suggesting a course of treatment, patients directly ask doctors to prescribe a certain kind of treatment that has not been suggested thus far in the consultation. They deploy different formats to make this suggestion: an imperative sentence, a *có…không* alternative question, or a declarative question. This suggestion occurs either as an expansion of the patient's response to the doctor's elicitation, or lies in a separate turn as part of the treatment sequence. Patients' use of the imperative sentence is exemplified in Extract 7.7. This is patient Thuong's DDF for her leg arthritis. This extract is located near the beginning of the consultation, when doctor Quy is undertaking history-taking. After presenting her concern, Thuong suggests taking some herbal steam therapy (arrowed).

```
Ex. 7.7: B 12 & 58
22  D:    khi: tê       vô+việ:n        là  #cũng# đa:u như  ri    à?
    Quy   on   previous hospitalisation COP also   pain same this INT

          'You had the same pain on your previous hospitalisation?'

23  P:    dạ: (0.5) đau  lâ::u rồi  bác    nã (.) nằm
Thuong    yes       pain age   PERF doctor PRT    treatment

24        đây  lâu  nhiều  lần  rồi (0.3)  mà::::::::: (.)
          here age  PL     time PERF       but

          'Yes. I've had it for ages and received lots of treatment at this
          hospital. But-'

25  D:    [hai-     ]
    Quy   two

          'Both-'

26  P:    [nghỉ hai ] năm ni  không nằm       nơi
Thuong    not   two   year now not   treatment PRT

          'I haven't come for treatment in the past two years'

27        (0.2)

28  D:    hai- hai- ha-  hai  châ:n ʃluôn à?
    Quy                  two  leg   PRT   INT

          'Both legs?'

29  P:    dạ:: (0.2) mà- mà  chân bên ni   thì đôi+(lúc) không đau¿
Thuong    yes        but leg in  this COP sometimes    not   painful

30        (.) chân bên ni   là  NHỨ:C lạ   này (0.3) chân chừ đi
              leg  in  this COP painful too PRT           leg  now walk

31        #không# được a (.) đi   mà  cà+dắ:c+cà+cò: đa::u  quá: đi+lẫn
          not     can  PRT  walk COP limp           painful badly PRT

          'Yes, but this leg sometimes isn't painful. The other one is too
          painful to walk on. I limp badly'
```

219

```
32  P:    =dạ đau  đay [này]
Thuong    HON hurt here PRT

          'It hurts here'

33  D:                [dạ ] phả::i  ha?
   Quy                 OK   right  INT

          'OK, the right leg?'

34        (0.3)

35  P:    dạ
Thuong    yes

          'Yes'

36        (5.1)

37  P:    nhờ  xô::ng      (.) à   chi  đó (0.3) hơ+đè::n      vó:i
Thuong    but  herbal+steam    uh  what it       infrared+light with

38        sóng+ngắn mò   hơ       nhiều lần  quá rồi
          shortwave but  infrared many  time so  PERF

          'But I've had herbal steam- no, what's it?, infrared light therapy
          with shortwave therapy so many times'

39        (0.7)

40  P:→  chừ: chuyến ni  bác    cho       xô:ng       a
Thuong   now  time   this doctor prescribe herbal+steam PRT

          'This time, please prescribe me some herbal steam therapy'
```

At line 22, doctor Quy asks if Thuong's previous hospitalisation was to deal with the same concern of leg arthritis. Thuong confirms Quy's presupposition and expands her turn to elaborate on her previous treatment (lines 23-24). She emphasises some key words, *lâ::u* ('ages'; line 23) and *nhiều lần* ('lots of'; line 24), to signal her experience with the problem and the treatment methods she has received at this hospital. Thuong then discloses the fact that she has not been hospitalised for the past two years (line 26). Quy gives no response to Thuong's information but continues his question on the problem (line 28). In response, Thuong describes the pain while also increasing its perceived severity (lines 29-32). Quy launches another question to locate the pain area (line 33), which is confirmed by Thuong (line 35). After a lengthy silence of 5.1 seconds in which Quy is probably doing a physical examination of her right leg (line 36), Thuong lists her previous treatment methods (lines 37-38) and closes her turn with a suggestion for herbal steam therapy (line 40).

Patient Thuong has been to this hospital numerous times before for the same concern of leg arthritis (lines 23-24). It is probable because of her previous visits that

she is able to list the previous treatments that she has had (lines 37-38) and suggest the one that she wants, *xô:ng* ('herbal steam therapy'; line 40). In particular, after a false start, *nhờ xô::ng* ('but I've had herbal steam-'; line 37), Thuong self-repairs her turn to abort that information. The pause-filler, *à chi đó* ('no, what's it?'; line 37), and two pauses (line 37) communicate her difficulties in recalling the previous treatments. However, she successfully lists her previous treatments, *hơ đèn* ('infrared light therapy'; line 37) and *sóng ngắn* ('shortwave therapy'; line 38), which she received at this hospital. After 0.7 seconds of silence (line 39) without any uptake from Quy, Thuong comes up with a suggestion for a different treatment approach, *xông* ('herbal steam therapy'; line 40).

Notice how patient Thuong properly organises the discourse to put forward her suggestion, even though the consultation is just in the history-taking phase. Based on Quy's elicitation of the pain quality in the past visit, Thuong recounts her medical history with an emphasis on the duration, *lâ::u* ('for ages'; line 23), and the amount of hospitalisation, *nhiều lần* ('lots of'; line 24). Similarly, when asked about the pain location (line 28), Thuong complains about its severity and its bad effect on her ability to walk (lines 29-32). The last chunk of information about her previous treatment (lines 37-38) is disclosed after a 5.1-second silence (line 36). Clearly, the three chunks of talk above are related to one another. The long duration, frequent visits, and pain severity, intensify the current problem and heighten the need for a more effective treatment, *xô:ng* ('herbal steam therapy'; line 40). Via this discourse organisation, Thuong requests Quy to provide her with the treatment method of her choice.

In summary, in response to the doctor's treatment options, patients not only show their agreement but also resist the doctor's agenda, negotiate the treatment plan, or suggest a treatment option of their own. In doing this, patients express their concern about their problem as well as their desire for effective treatment. While the first two practices are also used by patients in Western medicine (e.g., Koenig, 2011; Stivers, 2005c), the third seems to be a distinctive practice of Vietnamese medical consultations. However, it seems that some patients are quite active in both resisting the doctor's recommendation and proposing their own treatments. Notably, these cases are common in follow-up visits (e.g., Extracts 7.4 and 7.7) or with chronic pain patients (e.g., Extracts 7.5 and 7.7). In other words, such patient actions may have to

do with the type of condition they have (e.g., chronic, long term pain), and/or the kinds of treatments that are being proposed (e.g., traditional/herbal medicine, or home remedies such as exercise), both of which may put patients in a stronger epistemic position than in other kinds of consultations. It is also interesting to note that this active involvement on the part of the patient is out of keeping with the preconception that doctor-patient relationships in Vietnam are influenced by the hierarchical nature of Vietnamese society, such that patients in this context are regarded as passive recipients of medical treatment only (Fancher et al., 2010; Hoàng, 2008; G. T. Nguyễn et al., 2007; N. T. H. Phạm, 2014; K. Trần, 2009).

In the next section, I will examine how doctors extend the consultation to seek further information, and argue that this information is also integral to the diagnosis and treatment of health problems.

7.2 Prolongation of the consultation

Even when the consultation has been brought to a close, some of the doctors and patients in this study continue eliciting and disclosing information. This practice is considered as a candidate phenomenon as its instances in my data are limited. The sequence of prolongation is as follows: doctors close the consultation – a lapse of time – doctors or patients re-start the consultation. The elicited information during this prolongation can be either medically-related or medically-unrelated. The former information (e.g., symptoms, lifestyles) is concerned directly with the problem itself, while the latter (e.g., small talk) is not. Specifically, doctor Hung in Extract 7.8 below seeks information about lifestyle issues, while doctor Vinh in Extract 7.9 looks at symptoms and finalises the concern. In Extract 7.8, doctor Hung is treating outpatient Hue for her contorted mouth.

```
Ex. 7.8: B 10 & 41

273 D:      em              nằ:::::m (.) đây  bờ  để:::  à  (0.2) làm      luôn
  Hung    younger+sister lie            here PRT to   uh        treatment PRT

274       hãy¿ (.) để:: à::: (1.0)  châm+cứu   luôn (.) nghe+↑nhưa
          INT      to   uh          acupuncture PRT       INT

          'Please lie down here for your treatment- your acupuncture-'

275       (0.2)

276 P:    nhạ
  Hue     yeah

          'Yeah'
```

```
277      (0.4)

278 D:   đợ:::i  (0.7)  ba:     đi  mua  rồi  châm+cứu
  Hung   wait          father  go  buy  then acupuncture

         'while you wait for your father to buy some medication for the
         acupuncture'

279      (31.4) ((The doctor is probably moving to his table and filling
         out the medical record))³⁶

280 D:   (cực) ni   bờ  ăn   ngủ    được khôn?
  Hung   pain  this so  eat  sleep  can   INT

         'Has the pain affected your eating or sleeping patterns?'

281      (0.5)

282 P:   đượ:c  (0.2)  bình+thườ:ng
  Hue    yes           normal

         'No, they're normal'

283      (0.2)

284 D:   bình+thường  hi¿
  Hung   normal       INT

         'Normal?'

285      (0.4)

286 P:   dạ
  Hue    yes

         'Yes'

287      (0.3)

288 D:   rồi rồi
  Hung   OK  OK

         'OK, OK'

289      (2.0)

290 D:   ngườ:i có  sợ      LẠ:NH sợ       đồ chi  không? (.) hay+là::
  Hung   body   PRT tolerate cold  tolerate any thing INT        or

         'Do you have any difficulty tolerating the cold, or anything like
         that? Or-'

291      (0.5)

292 P:   dạ: (0.3)  không
  Hue    HON        no

         'No'

293 D:   bình+thường hi¿
  Hung   OK          INT

         'All OK?'

294      (4.4)

295 D:   rồ::i (0.2) (              )  em            nằm  đây  bờ  đợi
```

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³⁶ In the audio recording, the doctor's voice from line 280 onwards becomes lower than before. In addition, there is sound of steps at the beginning of the lapse at line 279 (see Section 4.6 for the doctor's filling out of the medical record in the outpatient ward).

```
  Hung    OK                      younger+sister  lie   here  PRT  wait
296        chậm       hi¿  (.)  rồ::i
           acupuncture INT        OK
           'OK, please lie down here for your acupuncture. OK'

297 P:     dạ
    Hue    OK
           'OK'
```

In lines 273-274, doctor Hung initiates the closing sequence through a *making of arrangements* (West, 2006) in which he asks Hue to lie on the sickbed for acupuncture. This means that the treatment plan has been negotiated and approved by both speakers beforehand, which tells us that the consultation has ended. This is also indicated by a lapse of 31.4 seconds (line 279), during which Hue is waiting for her father to go out and buy the medication for her acupuncture, and Hung is probably moving to his table and filling out the medical record. However, at this point, Hung extends the consultation by asking about Hue's lifestyle (i.e., eating and sleeping; line 280) and her ability to tolerate the cold (line 290). Both questions are designed with the *có…không* format that displays Hung's lack of knowledge of these issues. That is, this information has not been elicited thus far.

This extract features a consultation between a doctor and an outpatient. As described in Section 4.1.3, there is no more consultation when patients are receiving acupuncture, which is often delivered by a nurse or an intern. This means that doctor Hung will probably not do acupuncture for Hue later, so the consultation ends at line 278. As a matter of routine, at the end of the consultation Hung goes back to his table (in the same ward) to complete Hue's medical record (see Figure 4.7). Therefore, the extra talk is probably produced while Hung is filling out the record and Hue is lying on a sickbed nearby. In this light, there are two alternative explanations for Hung's expanding talk from line 280 onwards. On the one hand, Hung may need further information that he forgot to elicit during the consultation in order to complete the form. The information Hung elicits in this extract (i.e., about the patient's lifestyle) has not been elicited before during this consultation (data not shown). On the other, he may want to help Hue to pass the time while her father is buying the medication, and to build a rapport between them. Despite this, the extra information-seeking activity is institutionally-related and supports the treatment to some extent.

While doctors in the outpatient wards complete the medical record in the same

room, those in the inpatient wards can only do this in the staffroom (see Section 4.6), which means they have to finish the consultation beforehand. This is the case with doctor Vinh's first visit with inpatient Kieu in Extract 7.9 below. Kieu has had spondylosis for many years and has undergone treatment at several health centres before. This extract is taken after the treatment has been recommended (see Extract 7.1) and Vinh has already closed the consultation (line 330).

```
Ex. 7.9: B 7 & 64
330 D:    rồ:i       =#thôi#  mệ      nghỉ  hây¿
 Vinh    that's+all PRT      grandma rest  INT

          'That's all. Please have a rest'

331      (0.2)

332 P:   ↓dạ::
 Kieu    OK

          'OK'

333      (6.6)

334 D:→  chủ+yế:u là  mệ      đau  lư:ng thô:i¿
 Vinh    main     COP grandma ache back  only

          'Your main concern is backache'

335      (0.4)

336 P:   dạ (.) đau  lưng  thô:i
 Kieu    yes    ache back  only

          'Yes, it is'

337      (0.9)

338 P:   chỉ+có (0.3)  đau       (0.2)  NHỨC
 Kieu    just         painful          ache

          'My back's just painful. It aches'

339 D:   ừ::m
 Vinh    mmm

          'Mmm'

340      (0.2)

341 P:   thốn (0.3) thố:n+thố:n (0.4) ngồ:::::i (0.4)đứng  dậy (.)
 Kieu    sting      sting            sit          stand up

342      đứ:::ng  a  (.) mà  đi:::  a (0.9)đi   với  đứng  a  thì được
         stand    PRT     then walk  PRT       walk with stand PRT COP fine

          'It stings when I stand up quickly after I've been sitting. It's
          fine when I walk around after I've been standing'

343      (0.2)

344 P:   mà  ngồi xuống là  (0.5) đú:ng thì #hắn# THẮT   (1.1)
 Kieu    but sit  down  COP       stand COP  it    intense

345      đau  thắt    (0.9) chị::u #không# thấu (0.5) ngồ::i là  phải
         pain intense       bear   not     can        sit   COP have+to
```

225

```
346     chố:n  (0.2) đứng  dậy phải  chốn °nữa°
        hold         stand up  have+to hold also

        'But the pain's unbearably intense when I stand up right after
        sitting. I have to have something to hold onto when I've been
        sitting and then stand up'

347     (2.4)

348 P:  thắ:t  nhiều+khi::::(1.6) go    ruột        °luôn°
    Kieu intense sometimes         cramp intestine PRT

        'Sometimes it's so intense that my intestines cramp up'

349     (0.9)

350 D:  dạ::
    Vinh yes

        'I see'

351     (2.6)

352 P:  bở:i     quá  lắm        mới đi   đây,(.) °còn+khô::::ng° (0.6)
    Kieu because  pain unbearable PRT come PRT      otherwise

353     vì      đường+xá xa+xôi mà #không#+có+ai chở+đi đây
        because distance long  but no-one       bring PRT

        'I've had to come to hospital because the pain's unbearable.
        Otherwise, I have to stay home because of the distance, because
        no-one can bring me here'

354     (1.0)

355 P:  (            ) (1.2)  mà đau     quá thì phải    đi
    Kieu                        but painful so  COP have+to come

        'I've had to come here because my back's so painful'

356     (16.4)

357 D:  đau  không tê   xuống+dưới bàn  chân  mệ       hi?
    Vinh pain not   numb down       CLA  foot  grandma INT

        'The pain doesn't make your feet go numb?'

358     (0.2)

359 P:  [#không# tê:::-]
    Kieu not       numb

        'No, it doesn't'

360 D:  [chỉ+có       ]  đau     vùng lung thô:i
    Vinh just            painful area back only

        'It's just painful in your back area'

361     (0.3)

362 D:  lung của  mệ       là CƠ       #hắn# CO   (.) hây¿
    Vinh back of   grandma COP muscle    it    tense     INT

        'The muscles in your back have tensed up'

363     (0.3)

364 P:  má:::::y à:::::(.) mấy    bữa trước ǀa (.) là hai cái chân
    Kieu several  uh        several day ago   PRT    COP two CLA leg

365     ni   #hắ::::n#  (.) #hắn# moài lắm, (0.8) đây mà đi  ra
        these they         they tired very        here COP walk to
```

```
366        đó     là: (.) đi    không  nổi
           there  COP      walk  not    can

           'Several days ago, I couldn't walk with these legs of mine from
           here to there³⁷ because they were very tired'

367        (1.1)

368 P:     bờ   thời+gian  mơi+ni   #hắn#  bớt   là  vì        có      cái (0.2)
 Kieu      and  time       recently they   better COP thanks+to take  CLA

369        châm+cứu   mà    #hắ::n# bị    KHÓ:P    °a° (1.4)  bữa ni  (.)
           acupuncture while they   suffer arthritis PRT          day these

370        lên  ri  được  (1.2) chù::  có:  cá:i là: (0.3)  cái  lu::ng
           lift this can        current have PRT  COP        CLA  back

           'The arthritis has got better recently thanks to acupuncture. I
           can lift my legs up like this these days. My only current concern
           is my back'

371 D:     °dạ°
 Vinh      OK

           'OK'

372        (1.3)

373 P:     cái  lu:ng=chù cái  lu:ng cúi   xuống #không#  được
 Kieu      CLA  back now  CLA  back  bend  down  not      can

           'My back, now I can't bend down'

374        (0.4)

375 D:     mệ       nằm-(0.2) mệ      nằ:m  ri       hắn đỡ       đau  không?
 Vinh      grandma  lie        grandma lie   like+this it  decrease pain INT

           'Does the pain decrease when you lie down like this?'

376        (0.2)

377 P:     nằm  ri        đỡ    đau
 Kieu      lie  like+this less  painful

           'Lying down like this is less painful'

378        (0.5)

379 D:     thờ:i+tiết  thay+đổ:i mệ       có  đau  nhiều    không?
 Vinh      weather     change    grandma  PRT pain increase INT

           'Does the pain increase when the weather changes?'

380        (0.8)

381 P:     không (.) í:t
 Kieu      no        little

           'No, it only hurts a little'

382        (0.3)

383 D:     í::t   (.)  hây?
 Vinh      little      INT

           'A little?'

384        (1.1)
```

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³⁷ In 'from here to there', the patient is presumably pointing at both locations.

```
385 P:   nằm    ri        là  #hắn#  đỡ    đau      mà::  ở  nhà  là  nằm
  Kieu   lie   like+this  COP  it    less  painful  so    at home COP lie

386      CẢ     NGÀY  rúa¿  (0.3) chơ::      ngồi  dậy  mà đứng  xuống  là
         whole  day   PRT         otherwise sit   up   to stand down   COP

387      khó+khăn   ˥lắm   (.)  #hắn#  nhức
         difficult  very        it     painful

388 D:   dạ:
  Vinh   OK

         'OK'

389 P:   nhố::i   a
  Kieu   ache     PRT

         Lines 385-387 & 389: 'Lying down like this is less painful, so I
         lie down the whole day at home. Otherwise, it's very difficult and
         painful to sit up and stand up'

390      (0.8)

391 P:   #hắn-# (.) #hắn#  mệt    ˥lắm (0.9) mà  buộc+phải-
  Kieu   it        it     tired  very       but have+to

392      phải     đứng   dậy  đi::  (.) lui  đi   tới   rúa,
         have+to  stand  up   walk     back walk forth PRT

         'I have to stand up and walk around even when I'm very tired'

393      (6.6)

394 D:   tay  ni    có   gãy   #phải#+khô::ng?
  Vinh   arm  this  PST  break  INT

         'This arm used to be broken, didn't it?'

395      (0.6)

396 D:   #hắn#  gãy    đăng  bột      này¿
  Vinh   it     break  cast  plaster  PRT

         'It was in a plaster cast because it was broken'

397      (0.3)

398 P:   dạ  (0.2) #không#+phải gãy  (.) mà  #hắn#  bị::::  à::: (0.7)
  Kieu   HON        not          break      but it     suffer  uh

399      bị     lơ::::  (0.3) bị     hắn-  (.) hắn  nó::: a (0.6)
         suffer sprain        suffer       it   that PRT

400      vì::   có  cái há:i trái mít     (0.2) $hi  hi [hi]$
         because PST PRT pick CLA jack-fruit

         'It wasn't broken. I sprained it because I picked up a jack-fruit'

401 D:                                              [dẹ]
  Vinh                                              yeah

         'Yeah'

402      (0.5)

403 P:   hái  trái  mít          ƯỚT (.) mà  sợ     hắn (0.5) cũng  dại  (0.7)
  Kieu   pick CLA   jack-fruit   wet     and afraid it        PRT   mistake

404      sợ     #hắn#  rót   bể    đi  mà  giơ    tay  h(h)ú::ng
         afraid it     land  break PRT so  stretch arm  catch

         'I picked up a wet jackfruit but, because I was afraid it would
         break open when it landed on the ground, I made the mistake of
         stretching out my arm to catch it'
```

```
405      (1.6)

406 D:   có   bó    bột     #này#  (.)  #hắn#  lệ:ch    [#này#]
  Vinh   PST  cast  plaster  PRT         it     deform   PRT

         'It was in plaster. It's deformed now'

407 P:                                                [⌈dạ   ]
  Kieu                                                 yes

         'Yes'

408      (0.3)

409 P:   có:  bó    bột     ⌈đó
  Kieu   PST  cast  plaster  PRT

         'Yes, it was in plaster'

410 D:   nhìn+thấy  cái  tay  #hắn#  lệch    này
  Vinh   look       CLA  arm  it     deform  PRT

         'Look! This arm's deformed'

411      (0.4)

412 P:   $hi   hi$
  Kieu

413      (0.9)

414 D:   cái  khớp   người+ta  thẳng     nì:: (0.3)  đây   mình  bị   lệch
  Vinh   CLA  joint  people    straight  PRT         here  you   get  deform

         'A normal joint is straight, but yours is deformed'

415      (1.4)

416 P:   đụng  (.)  tui  đụng  bờ   bị:::: (0.2)  nó::  đó:
  Kieu   catch      I    catch  and  suffer       that  PRT

         'I sprained it because I tried to catch that jackfruit'

417 D:   ⌈ừ::::
  Vinh   mmm

         'Mmm'

418      (2.5)

419 D:   tay  ni:: (0.2)  ĐẸ:::P      đi (0.9)  hai #cái# tay (0.2) $hi [hi$]
  Vinh   arm  this        beautiful   PRT       two  CLA   arm

         'This arm's beautiful. Both arms are'

420 P:                                                            [$hi]
  Kieu

421      hi   hi   hi$

422      (0.9)

423 D:   rồ:i (.)  thôi      mệ       nằm  nghi  hi?
  Vinh   OK        that's+all grandma  lie  rest  INT

         'OK. That's all. Please have a rest'

424 P:   dạ::
  Kieu   OK

         'OK'
```

229

As line 330 reveals, doctor Vinh's *possible pre-closing* (Schegloff & Sacks, 1973), *rồi* ('that's all'), plus *close-implicative element* (Jefferson, 1988), *thôi mệ nghỉ hây* ('please have a rest'), signal that Kieu can have a rest now, and that the consultation is over. Kieu's uptake at line 332 registers her alignment with Vinh's request. The closure is also marked by a lapse of 6.6 seconds (line 333), after which Vinh passes a finalisation in his third closing turn to extend the consultation (line 334). This undercuts the closing initiation and triggers a *drastic movement out of closings* (Button, 1990), which is used when a speaker does not orient to closing the consultation. Vinh's medical finalisation legitimises Kieu's "claims to being ill and access to the sick role and its incumbent rights and responsibilities" (Heath, 1992, p. 260). In fact, based on this finalisation, Kieu develops a long narrative to intensify the perceived severity of her problem (lines 338, 341-342, 344-346, and 348) and establish the reason for today's visit (lines 352-353). Notably, Vinh receives the narrative with two response tokens, *ừ::m* ('mmm'; line 339) and *dạ::* ('I see'; line 350), as continuers (Jefferson, 1989). He does not make any comments during or at the end of the narrative (marked by a lapse of 16.4 seconds at line 356). At this stage, Vinh carries out a verbal and physical examination (lines 357 and 360) and delivers a diagnosis (line 362). This action looks like a re-start of the consultation, from which point Kieu develops another narrative about her leg and back pain (lines 364-366, 368-370, and 373). Vinh only produces an acknowledgement token, *ᵒdạᵒ* ('OK'; line 371), in a soft voice to invite Kieu to continue. From lines 375 to 392, the sequence of talk continues with Vinh seeking the symptoms and Kieu narrating her backache. After 6.6 seconds of silence (line 393), Vinh abruptly shifts the topic to Kieu's previous broken arm (from line 394 onwards), which is irrelevant to the main concern (i.e., spondylosis) and to the whole consultation. Also, this new topic includes Kieu's narrative in which she reports the cause of her sprained arm (line 399). Through her narrative of picking up a wet jackfruit (lines 403-404), Kieu inserts her voice of the life-world. It is not until line 423 that the prolongation of the consultation officially terminates.

Doctor Vinh collects two types of information through the prolongation of the consultation: one relating to the current concern (i.e., spondylosis) and the other to a past problem (i.e., the broken arm). The first type is a valuable addition to the treatment regime, as it includes information about medical history, physical examination, and diagnosis of the spondylosis. The second one, however, is

unrelated to the consultation as a whole, as it neither deals with the current concern nor raises any new concern (as the broken arm happened long ago and the patient has recovered now). In other words, this second topic provides the grist for some social conversation, especially in lines 419-421, where both doctor and patient share laughter about the problem. The topic ends with no complaints from the patient about this accident; therefore, no solution or treatment recommendation is produced for it.

It can be seen that, although both doctors in Extracts 7.8 and 7.9 have closed their consultations, they extend them after some time in order to seek information to further support their treatment, as some information may be skipped during the consultation. Hence, their expansion practices are institutionally relevant to the consultations as a whole. From a medical perspective, their course of action also indicates that the doctor strategically manages the consultation on a case-by-case basis so as to ensure the best outcome for patients. Moreover, some of their expansions can be regarded as social talk with little relevance to the major concern. Even so, this practice may help to strengthen the doctor-patient relationship in Vietnam, where there is typically some social distance between doctors and patients. However, since the consultations were audio recorded only, the participants' conduct in the re-opening sequence cannot be observed directly.

7.3 Chapter conclusion

Chapter 7 has presented the information-seeking activities during treatment stage and post-consultation. In recommending treatments, some doctors seek the patient's agreement with the treatment plan while others offer multiple treatment options for patients to choose from. Of note is the relationship between the visit locations (i.e., consulting room or ward) and the practices involved in treatment recommendation. In particular, seeking the patient's agreement with the treatment plan is common in the wards, while offering multiple treatment options is widely used in the consulting rooms. This reflects the fact that the types of hospital where the data were collected impose certain institutional constraints on how doctors make treatment recommendations in this context. Significantly, both of these recommendation practices engage patients in the treatment decision process, and so indicate the doctor's inclination towards a shared decision-making style in medical consultations (Charles et al., 1997). In response to the doctor's treatment recommendation, patients

resist the doctor's agenda, negotiate the treatment plan, or suggest a course of treatment. The adoption of each practice is shaped by various factors such as patient's epistemic stances, the characteristics of their problems, the doctor's elicitation, or the visit type. However, out of keeping with the established preconception that Vietnamese patients are passive recipients in medical consultations (Fancher et al., 2010; Hoàng, 2008; G. T. Nguyễn et al., 2007; N. T. H. Phạm, 2014; K. Trần, 2009), the patients in this study are not passive at all, as they can and do resist the doctor's agenda or propose their own treatments. Overall, through their negotiation of the treatment recommendation, not only the doctors but also the patients in my study display an orientation to a shared decision-making process in which the patient's voice is valued.

This chapter has shown that information-seeking activities are not restricted to the initial stages of the consultation, and that treatment recommendation is not just intended to provide treatment plans or educate patients. Rather, information-seeking activities also occur after the close of the medical visit, and through the treatment stage. The prolongation sequence demonstrates how the doctor strategically manages the consultation through their interaction organisation in order to obtain further information that may otherwise be missed. Also, this practice provides insights into the patient's life-world concerns, which brings doctors and patients closer. Having gone through the information-seeking activities across the main stages of the consultation, the thesis now turns to the concluding chapter to look back at the research aims and research questions.

Chapter 8

Conclusion

8.0 Introduction

In this chapter, the key findings of the study are discussed (Section 8.1). Then I state the main contributions of this research (Section 8.2). The chapter ends with limitations of the study, and suggestions for further research (Section 8.3).

8.1. Discussion of the overall findings of the study

Although the information-seeking activities in doctor-patient interaction play a key role in the success of a consultation, the current literature on information-seeking activities has exhibited some limitations. In addition, the structure of Vietnamese medical discourse in general, and information-seeking activities within this cultural context in particular, is relatively unknown. Therefore, the aim of this study was to examine the information-seeking practices during medical consultations at two public hospitals in Vietnam. It has used CA to analyse the verbal interaction of both doctors and patients in the course of seeking and disclosing information.

8.1.1 Research question 1: How do doctors elicit and seek information from their patients in medical consultations?

Across the three main stages of the information-seeking activities in the medical consultation, doctors adopted different elicitation practices. While their practices during problem presentation varied with the types of visit (i.e., first visit, SDF, and DDF), the patterns of elicitation during the history-taking and physical examination stage were the same regardless of the visit type. The distinctive feature of the treatment phase created two other patterns of elicitation which also varied with the types of visit. Overall, the emergence of various elicitation patterns in accordance with the different stages reflected the doctor's interactional organisation of discourse in the practice of eliciting information.

During problem presentation stage (see Chapter 5), the patterns of elicitation differed across first visits, SDFs, and DDFs. For the first visits, doctors often displayed their lack of prior knowledge of the patient's problems (see Extract 5.1). Therefore, their elicitors often had a wh-question design that embodied a

presupposition about the existence of a problem. Doctors in SDFs, in contrast, communicated that they had some knowledge of the patient's main concerns from their previous consultation with that patient. The most common format of the SDFs was to seek the patient's evaluation of their health since the last visit, or review the previous concerns in order to set the foundation for the current one (see Extract 5.5). In a typical DDF, doctors also had some prior knowledge of the patient's concern(s); however, this knowledge was gained from the patient's medical records or referral letter, rather than from their previous consultation. For this reason, the elicitation format used in these visits tended to focus on the patient's presentation of their previous concern(s). Notably, some follow-ups did not have any elicitation at all (see Extract 5.15). The absence of elicitation does not mean that doctors have forgotten this step. Rather, they were pre-empted by patients. Sometimes doctors skipped this step because the reasons for the visit were already available, and thus proceeded with further activities to steer the exchange according to their own agendas. This type of 'no elicitor' follow-up visit should be distinguished from a first visit, wherein the patient's concern was still unknown to doctors.

While most of the doctor's elicitors were designed to reflect the visit type, some were not. In some first visits, the doctor's questions displayed the doctor's strong epistemic stance toward the patient's problem in question (see Extract 5.2). These questions were used by doctors in the wards, to which patients were referred by another doctor in the consulting rooms. Hence, the doctor's knowledge was often gained from the patient's medical records or referral letter. Similarly, the doctors in follow-up visits sometimes produced a new-concern elicitor (see Extract 5.4). Notably, these cases occurred mostly in the SDFs to the consulting rooms or in the DDFs at both locations. Significantly, the doctors did not monitor the patients' progress on a regular basis in the SDFs to the consulting rooms, or did not read the patient's medical records or referral letter in the DDFs.

The unsuitability of the doctor's elicitation format may be reflective of one or more of the challenges faced by doctors in keeping informed about their patients' health problems in Vietnamese public hospitals.[38] To begin with, patients sometimes neglected to bring their medical records with them to the consultation: if this happened, it goes without saying that doctors would have no information to refer to

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[38] I have identified each of these challenges based on my observation of this hospital system, and/or my own data.

beforehand. Second, doctors in this system had to deal with a large number of patients each day. Other challenges were specific to the consulting-room environment: while ward doctors examined a given patient daily, consulting-room doctors typically attended to a given patient only once; and whereas outpatients or inpatients tended to return for a follow-up within a few days, consulting patients did not adhere to a specific timeframe but returned anytime they felt it was necessary. In short, these factors contributed to different epistemic stances on the part of the doctors towards different patients, which, in turn, shaped their elicitors to a great extent.

There was also one difficulty which confronted ward doctors in particular. Whenever a patient was sent to this room, they had to submit their medical record to the receptionist. This happened regardless of whether the patient was in hospital for a first visit or a follow-up. It was then up to the ward doctor to collect this record from reception before the consultation. However, if the doctor was particularly busy, they might not have the opportunity to retrieve it in time. A difficulty such as this may account for why ward doctors displayed a lack of necessary background information about a follow-up patient's problem in some instances. By contrast, an inpatient or outpatient in a first visit to the ward had to be examined by a doctor in the consulting room beforehand. Therefore, the doctors in a first visit to the ward were able to obtain some information about the patient's problem(s) through their medical records or referral letter. This explains why their elicitors tended to convey their strong epistemic stances vis-à-vis the patient's problem(s).

The doctors' elicitation of problem presentation is an important feature of the whole visit by virtue of its direct effect on the patients' manner in presenting their concerns. My data has illustrated the doctors' flexibility in varying their turn design in accordance with different kinds of visit. Particularly, doctors adopted specific question types (e.g., general inquiry, alternative, or declarative) in pursuit of particular information. These question designs embodied different presuppositions about the patients' problems, thus conforming to the principle of problem attentiveness in medical questioning. In addition, these designs reflected various epistemic gradients that doctors had about the patient's problem(s). Their epistemics were then institutionally constrained by the characteristics of Vietnamese hospitals. Interactionally, their elicitors influenced the patients' disclosure of problem. In turn, the patients' concern presentation shaped the social interactional organisation of the

whole consultation and was shaped by the doctors' initiation (Heritage & Robinson, 2006a; Robinson, 2006).

During history-taking and physical examination (see Chapter 6), doctors deployed four elicitation practices to obtain information related to current problems and medical history: (i) questions, (ii) full or partial repeat of patient's response, (iii) fishing devices or examples, and (iv) assessment of patient's information. These elicitation practices were also used during other stages of the consultation. Notably, these practices were locally and indexically bound by the visit types, the doctor's epistemic position, and their local organisation of talk as the consultation developed. Hence, the doctor's strategic management of the overall structure of the consultation was reflected in their design of practices that embodied certain presuppositions about the patient's problem(s), and that also conformed to the fundamental principles of medical questions: recipient design, optimisation, preferences, and problem attentiveness.

As Heritage and Clayman (2010) posit, most medical consultations involve a great number of doctor questions, and these questions mostly emerge during the history-taking phase. This was also the case in this data. Although doctors employed various strategies in the course of seeking information from patients, questions were the main device that they used to do this. Doctor question formats ranged from alternative to non-alternative forms with general, detailed, and general-to-detailed questions. Interestingly, although some general questions had broad content, they did not often gain much information. This is because they elicited general information. Further, the received information was often vague in that it failed to evaluate the pain progress properly. For example, through the question *có đỡ không?* ('has the pain eased?'), doctors want to know whether the patient's pain has eased or not. They do not require further information. Therefore, the patient's 'yes' or 'no' answer does not tell us exactly the level of recovery. In contrast, detailed questions focused on the specific issues, thereby enabling the doctors to gain deeper insight into the problem. General-to-detailed questions were commonly utilised when the doctor sought the information about pain duration or past problems (see Extracts 6.9 and 6.16), and thus they were able to obtain information from different angles. Besides three questioning strategies above, some doctors also combined summarisation with questions (e.g., Extracts 6.11 or 6.16). This combination was used to make sure that patients did not miss any previous treatments, past problems, or unmet concerns. The

majority of the questions were syntactically or intonationally appropriate and appeared to be understood by patients, as evidenced through their relevant responses. However, there were questions that failed to get expected responses. Faced with this situation, some of the doctors re-issued new questions by partly or wholly repeating the previous ones or narrowing down their scope (e.g., Extract 6.15).

It is noteworthy that there was another strategy that a large number of doctors adopted to seek information: partial or full repeats of the patient's response (e.g., Extracts 5.5, 6.12, 6.13, and 6.16). In each case, this repeat lay at the third turn in a three-turn sequence: doctor's question, patient's response, and doctor's repeat of patient's response. On receipt of the patient's information, doctors in other cultures often produce a sequence-closing third to close off the question-answer sequence, pose another question to narrow down the scope of the patient's response (Park, 2011), or project a new topic. However, the Vietnamese doctors in this study tended to repeat the patient's response instead. Via partial or full repeats, doctors aimed to perform seven functions: (i) eliciting information, (ii) initiating repair, (iii) confirming the information, (iv) registering receipt of the prior turn, (v) displaying the doctor's stance, (vi) holding the conversational floor, and (vii) directing a particular topical focus in conversation, in particular, checking or confirming the patient's response. In return, doctor repeats were able to trigger the patient's further elaboration (e.g., Extracts 6.12 and 6.16). Overall, my data suggested that this mode of elicitation may be a distinctive feature of Vietnamese medical discourse.

Apart from questions and repeats, doctors also used fishing devices (e.g., Extract 6.9) or examples (e.g., Extracts 6.4 and 6.6) to elicit information. Both practices were positioned in the middle of the sequence of several adjacent pairs, and communicated the doctor's strong epistemic stance towards the issue. Syntactically, fishing devices and examples did not have an interrogative format; however, they both occasioned the patient's disclosure of some information that was critical to the diagnosis and treatment recommendation. Notably, these strategies did not obtain more information than the questions did. This was partly due to the doctors' formulation of these information-seeking acts, which typically looked only for confirmation or disconfirmation. However, by using this device, doctors could track the correct version of the information, and elicit authoritative descriptions from patients (Bergmann, 1992).

A candidate phenomenon of information-seeking strategy adopted by doctors was making assessments of the patients' information. Like the strategy of partial or full repeats, this also lay in the third turn, when the doctors received the patients' information. Some assessments were interrogatively structured while others were in the form of a statement (e.g., lines 40-41 in Extract 5.14), an exclamation, or a positive comment (e.g., lines 175-176 in Extract 6.13). Although most of these assessments did not seek information overtly, they triggered patients' disclosure of a large amount of information (see Extracts 5.14 and 6.13). In adopting this practice, the doctor took on the role of a medical expert who offered guidance regarding the patient's problem(s). This candidate phenomenon may also be a potential strategy of doctor elicitation in Vietnamese doctor-patient interaction.

Turning to the treatment phase (see Chapter 7), two patterns of elicitation were identified: seeking the patient's agreement with the recommended treatment plan and offering multiple treatment options. The former pattern was pervasively used by doctors in the ward while the latter by those in the consulting room. The doctor's adoption of each practice in each location was institutionally bound by the examination procedure of, and their medical responsibilities designated by, the research hospitals. In the former practice, some of the doctors tended to state the treatment without explicitly seeking the patient's agreement. This interactional action may be partly shaped by the hierarchical structure of Vietnamese society. To begin with, the doctor-patient relationship itself in this culture is basically asymmetrical. While the doctor has more respect and more prestige than the patient in almost any social situation (Wolinsky, 1980), doctors in Vietnamese society, together with priests and teachers, are in professions which are even higher in status than others (LaBorde, 1996). They occupy a privileged position and are treated with great respect and admiration by patients and the whole society. This is reflected through the fact that doctors pursue their own agenda without explicitly seeking input from patients.

Even so, the fact that doctors were willing to put treatment decisions in the hands of patients, whether through seeking the patients' agreement or through offering them several treatment options, raises questions about the pre-conceptions of the Vietnamese doctor-patient relationship. Involving patients in treatment decisions like this reflected the positive attitudes on the part of the Vietnamese doctors, who are used to being the gate-keepers in medical consultations. By offering

patients multiple options, doctors could also gain some more insight into the patient's inner world, and express sympathy for, and understanding of, the patient's health problems (e.g., Extract 7.3).

Having discussed the doctor elicitation throughout the consultation, let us look back at the literature review in Chapter 3 to identify any similarities or differences regarding the findings between previous studies and the current study. First of all, there are several studies whose findings on the doctors' initiations of problem presentation in Vietnamese and other cultural contexts are quite similar to the present study. For instance, the patterns of elicitation in first visits in the consulting room are the same as those identified by N. T. H. Phạm (2014) in her study of first visits in a Vietnamese context. In addition, most of the patterns of eliciting new and follow-up concerns are somewhat the same as those in Robinson (2006). Three out of five question formats in Heritage and Robinson (2006b) were adopted by the doctors in my data (i.e., general inquiry questions, gloss-for-confirmation questions, and history-taking questions). This means that I did not present candidate phenomena but true collections of cases (Hoey & Kendrick, 2018) which have been verified in the key studies identified above.

However, probably due to the institutional differences between Vietnamese hospitals and Western hospitals, some elicitors used in the first visits in the ward, SDFs in the consulting room, and DDFs in both settings in my data, did not reflect the visit types. Further, while the Western equivalents of patterns *khỏe không?* or *thế nào rồi?* (either of which is translated as 'how are you?' or 'how are you doing?') are quite prevalent in Western medical discourse (Coupland, Robinson, & Coupland, 1994; Heritage & Robinson, 2006b; Robinson, 2006), this is not the case with my data set. In Vietnam, the phrases *khỏe không?* or *thế nào rồi?* are common in mundane interactions among intimate relationships (H. N. Lương & Lê, 2008). This difference in their use across settings most likely accounts for the absence of these formats in my data.

Another similarity between previous studies conducted in cultural settings other than Vietnam and my study is the doctors' elicitation strategies. In particular, doctors in both settings used general elicitation, general-to-specific elicitation, and fishing devices to pursue information (e.g., Bergmann, 1992; Goto & Takemura, 2016; Maguire et al., 1996; Takemura et al., 2007). One more feature is the doctors' chaining of two questions in one turn (e.g., Extracts 5.1, 5.2, and 6.12). Similar to

Cordella (2004) and West (1983, 1984a), I also found that the patients in my data often addressed the last question.

The last similarity is concerned with the doctor's delivery of the treatment recommendation. First of all, similar to doctors in Western culture (e.g., Stivers, 2005b, 2006), the doctors in this study also offered their recommendation for or against a particular treatment. In addition, although seeking the patient's agreement with the recommended treatment plan was sometimes implicit, which may be considered as a form of imposition on the patient, some of the doctors also offered multiple treatment choices for the patient to choose from. This means that, to some extent, Vietnamese doctors seemed to share the same interactional strategies observed in Western culture (e.g., Fisher, 1983; Koenig; 2008, 2011; Roberts, 1999). However, while the asymmetry between doctor and patient is probably becoming less pronounced in Western medicine (e.g., Stivers, 2002a, 2005b, 2005c, 2006, 2007), it is still evident in the Vietnamese doctor-patient relationship.

The findings have shown that doctor elicitation in this study was shaped by the institutional context of Vietnamese public hospitals in many respects. First of all, the follow-up visits in this study were of two kinds (i.e., SDF and DDF; see Section 4.3), which resulted in different patterns of talk in the generally same type of visit. Secondly, as all inpatients and outpatients were referred from the doctors in the consulting room, the doctors in first visits to the wards sometimes formulated their problem-presentation elicitors as if the visits were follow-ups (e.g., Extract 5.2). By contrast, some doctors in DDFs to the ward were too busy to read the patient's medical records or referral letter prior to the consultation; consequently, they ran the consultation as if it were a first visit. Lastly, while in Western medicine the patient's medical information can be transferred online between health centres, this is not the case in Vietnamese medicine. This means that doctors had to elicit some information that was already available in the patient's medical records. These features of consulting procedures at Vietnamese public hospitals may, in part, give rise to the interaction patterns in Vietnamese medical consultations.

Culturally, the pervasive use of doctor questions in the corpus, to some extent, reflected the Vietnamese cultural influences on institutional talk. As presented in Section 2.2, the Vietnamese doctor-patient relationship is constrained by social hierarchy and power distance. Under this cultural norm, higher social status is typically afforded to doctors, while patients are often considered the less powerful

group in medical consultations. Given that "as long as one is in the position of doing the questions, then in part one has control of the conversation" (Sacks, 1995, p. 55), doctors, by virtue of their higher social status, employed questions not only to pursue information but also to monitor the consultations. In doing this, doctors oriented patients to the doctors' agendas and treatment plans (Drew & Heritage, 1992). This helped the consultations to stay on track and conclude in a timely manner. From a CA perspective, the doctor organisation of questions should be considered within "locally constructed discourse statuses" rather than through the lens of a social hierarchy (Drew & Heritage, 1992, p. 48). In other words, the pervasive use of their questions could be traced to the asymmetry between doctors and patients regarding their differential states of knowledge, and the relationship between status and role as well as discursive rights and obligations. However, this asymmetry may be augmented in the Vietnamese medical context given the great social distance between doctors who are often credited with a higher status and patients with a lower status. This probably accounts for the great number of doctor questions in this study. H. T. T. Trương (personal communication, June 20th, 2016) told me that, without questions and interruptions, patients often deviated from the consultation by narrating unrelated details, which delayed the process of eliciting key information. This demonstrated the doctors' control over the whole consultation (Ainsworth-Vaughn, 1994; West, 1984a).

Given the importance of the information-seeking activities to the consultation as a whole (Bickley & Szilagyi, 2013; J. Silverman et al., 2013), the findings of this study extend the knowledge about how doctors elicit information from their patients. In each of the visits analysed in this thesis, we have seen that, regardless of the visit type, the doctor's elicitation of the patient's health concern shaped how patients disclosed this concern. It was also clear from my data that the doctor's inappropriate elicitors were commonplace in medical consultations in Vietnamese public hospitals. The upshot is that there was potential for adverse effects on patient disclosure and, by extension, the outcome of the visit itself within this medical context (Robinson & Heritage, 2005) if doctors use an inappropriate format in their problem solicitation. The inappropriate elicitors illustrated this effect because patients aligned their response with the doctor's question even though this question was incongruent with the actual visit type (e.g., line 4 in Extract 5.3; lines 6, 8, and 10 in Extract 5.4). If doctors' elicitors are appropriate to the visit types, this may save their time and

energy. The appropriate elicitors can trigger the patients' disclosure of exact information; thus, the patients' main concern may be resolved more quickly and effectively. Moreover, it would be easier to implement this recommendation if patients were required to bring their medical records to consultations.

According to General Statistics Office of Vietnam (2017), the number of patient beds per 10,000 inhabitants in 2016 was 26.8 beds, which is much lower than numerous countries in the world (Eurostat Statistics Explained, 2017). This number means that the public hospitals in Vietnam need more beds to meet the increasing demand of patients, given the overloaded situation at public hospitals, where doctors often face a heavy workload (Dương & Anh, 2018). However, while waiting for the hospital facility to be upgraded, doctors themselves can help overcome this situation to some extent through their medical consultations with patients. If consultations have positive outcomes, it is likely that patients' health will be improved.

8.1.2 Research question 2: How do patients disclose information to their doctors in medical consultations?

Most of the patients disclosed information to their doctors by responding to the doctors' information-seeking elicitors. Their turn of talk sequentially lay at the second-pair part of an adjacency pair where the doctors' elicitation was the first-pair part. Consequently, their disclosure was shaped by the doctors' interactional action and topical agenda. However, their responses were not simply intended to provide information that had been requested of them. Rather, through responding to the doctors' questions, patients disclosed further information, such as their preference for treatment (e.g., Extract 7.7), or making their voice of the life-world heard (e.g., Extract 7.9). These implications varied across different stages of the consultation.

During the initial stages of the consultation (see Chapter 5) patients disclosed their major concerns to doctors. Their presentation was designed in the form of a 'doctorable' problem that was worthy of medical attention (Heritage & Robinson, 2006a). The most common format of disclosure was general-to-specific presentation (e.g., Extracts 5.1, 5.4, and 5.9). In addition, depending on the visit types (i.e., first visit, SDF, or DDF), pain quality (i.e., chronic or acute), and their relationship with doctors, patients strategically formulated different practices in the course of presenting their problems. Some disclosed one concern at a time (e.g., Extract 5.9) while others chained multiple concerns together (e.g., Extract 5.14). Chronic-pain

patients often gave a narrative integrating multiple chunks of information about the development of the problem and their remedy as a means of describing, or emphasising the severity of, the problem (e.g., Extract 5.14). By contrast, the presentation of acute-pain patients was often simpler (e.g., Extract 5.9). In addition to presenting their concerns, patients also tried to disclose extra details, such as speculate about the causes of problem (e.g., Extract 5.12), make their assessments to update the doctors on their health condition (e.g., Extract 5.11), put forward the diagnosis confirmed by other health providers (e.g., Extracts 5.10 and 5.12), or state the reason for choosing this hospital (e.g., Extract 5.13). Moreover, there were cases when they fully grasped their own problem, hence pre-empting the doctor's elicitation (e.g., Extract 5.15). Notably, the practices of symptoms-only presentation and presentation plus diagnosis are quite common in the wider literature (e.g., Ijäs-Kallio et al., 2010; Pomerantz, 2002; Stivers, 2002b; see Section 3.3.2.3).

During history-taking and physical examination (see Chapter 6), patients employed five different strategies to disclose information to doctors: (i) using examples, (ii) producing a narrative, (iii) invoking the opinion of a third party, (iv) elaborating on their response, and (v) making a list. Although these five strategies occurred throughout the consultation, they are frequently employed to provide information related to current problems or medical history (i.e., during history-taking and physical examination). 'Using examples' is a common strategy to disclose the information of symptoms, recovery assessment, or lifestyle issues. This example practice is positioned as a response to the doctor's elicitation, or as an expansion of their responding turn. In particular, patients described their life difficulty (e.g., lines 20-22 in Extract 5.14), described an event they joined, or disclosed their daily routine (e.g., lines 273 and 275 in Extract 6.12). Through these example-using practices, patients justified their claims, gave doctors further insight into the problem, or voiced their life-world concerns.

'Producing a narrative' is utilised to suggest the cause of the problem, present the reason for today's visit, or describe the patient's basic activities. For instance, some patients disclosed the probable cause of their problem by anchoring their narrative to a past accident or to a recent physically-demanding task (e.g., Extract 5.12). Other patients produced a narrative of their medical history as problem presentation (e.g., Extract 5.14), or a narrative of their basic activities (e.g., Extract 6.13). This practice was often composed of multi-unit turns, which led to long

sequences of talk. Typically, this narrative strategy is employed by the chronic pain patients, or by those whose pain occurred long time ago. As a narrative often incorporated multiple types of information (e.g., diagnosis, symptoms, reason for the visit, past diagnoses and treatments, or cause), it gave doctors a broad picture of the problem, which may have saved their elicitation to some extent. As can be seen from Extracts 5.12 and 5.14, via the narrative, the patient did not provide the requested information directly, which reflected the indirect communication style of Vietnamese (see also Section 2.2).

'Invoking the opinion of a third party' was the patients' usual practice to convince doctors of the patients' claim on some issues. By invoking the opinion of a third party, patients could reinforce their information on the one hand, and reduce their own agency and accountability regarding the information on the other (Heritage & Robinson, 2006a). This was a common strategy for patients to update their health condition after one course of treatment, disclose past diagnoses (e.g., Extract 6.4), or obtain a preferred form of treatment (e.g., Extracts 7.4 and 7.5). The third parties to be invoked ranged from medical professionals (e.g., their previous doctors), outsiders, and family members, to medical relatives.

'Elaborating on their response' means patients expanded their talk to disclose further information that was not asked by doctors. This practice was often positioned as an expansion of a turn that responded to the doctor's elicitation, or occurred after a doctor acknowledgement token (e.g., 'yes', 'mmm'). This strategy was commonly adopted in providing information about recovery assessment (e.g., Extracts 5.3, 5.8, and 5.11), basic activities (e.g., Extract 6.12), past problems (e.g., Extract 6.17), or past diagnoses and treatments, or in establishing the reason for the visit (e.g., Extract 5.13). By elaboration, patients pre-empted the doctor's further questions by providing some information that may be off the doctors' agenda, thus offering doctors further insight into their health problems. This, in turn, might have informed the doctors' diagnosis and treatment.

The last strategy that patients used to disclose information was 'making a list'. The list was often constructed with three parts, in which the last part served as a generalised list completer. Patients often made a list of the current problems during problem presentation stage (e.g., Extract 5.4), the past problems, or the causes of the problem (e.g., Extract 6.5). While the list of current or past problems aimed to

provide all concerns to doctors in an orderly manner, the list of causes opened up possibilities for doctors to rule in or rule out the main cause of the problem.

Even at the final stage of the consultation, patients also disclosed information about their treatment preference and the medically-related or medically-unrelated information through the prolongation of the consultation (see Chapter 7). On receipt of the doctors' different treatment recommendations, some patients accepted them passively without any queries or comments (e.g., Extracts 7.1 and 7.2), while others actively resisted the doctors' agenda (e.g., Extract 7.4), negotiated the treatment plan (e.g., Extract 7.6), or kept requesting a particular type of treatment until this was granted by doctors (e.g., Extract 7.5). Their active participation displayed their strong epistemic stance towards the treatment plan, where this stance was probably related to the types of conditions they had or the treatment plan being proposed. Such active involvement expressed their responsibility and concern toward decisions relating to their own health, and also reflected their own experience with the problem. In doing this, they voiced their expectation of effective outcomes. Apart from requested information, some patients also volunteered other information of the symptoms or their life-world concerns (e.g., Extract 7.9).

Despite the fact that my data were gathered in the Vietnamese context, some of the disclosure strategies used by the patients in this study were the same as those reported in previous research in other cultural contexts. For instance, 'patient producing a narrative' was found in Halkowski's (2006) study in an English-speaking context, while 'invoking the opinion of a third party' was employed by the patients in the works of Gill and Maynard (2006) and Heritage and Robinson (2006a). This supports the possibility that the strategies used by patients to disclose information may be relatively invariant across cultures. However, the previous studies just examined the patients' disclosure practice in some specific stages of the consultation, not the whole consultation; for example, Stivers and Heritage (2001) focused on history-taking while Stivers (2002b) and Ijäs-Kallio et al. (2010) looked at problem presentations. Moreover, the research scope of these studies tended to be restricted to a specific practice of disclosure (e.g., how patients expanded their talk to volunteer more information).

With the aim of becoming well again as quickly as possible (Parsons, 1951), all patients expect to receive a solution to their problem (Stivers, 2006), and thus disclosure of information to their doctor is a necessary practice. The information

could be either directly or indirectly relevant to their health problems, or even medically-unrelated. The fact that some patients voiced their own expectation (e.g., Extract 7.7) or kept requesting a particular type of treatment until doctors granted it (e.g., Extract 7.5), to some extent, raises questions about the preconceptions which underlie the Vietnamese doctor-patient relationship. Under the influences of collectivism and Confucian values, patients have long been regarded as passive recipients in interactions with doctors – a highly respected figure (e.g., Fancher et al., 2010; H. Hoàng 2008; G. T. Nguyễn et al., 2007; N. T. H. Phạm, 2014; K. Trần, 2009). However, some patients in the current study were not passive recipients at all.

8.1.3 Research question 3: What information is elicited and sought by doctors and disclosed by patients in medical consultations?

The majority of the doctors in this study followed the structural framework identified by Byrne and Long (1976; see Section 3.2). Particularly, doctors often elicited the patients' major concerns at the outset of the consultations, and used this to guide their information-seeking activities (see Chapter 5). Doctors then proceeded with the history-taking and physical examination stages, in which two categories of information were sought: information related to the current problems, and information about the medical history (see Chapter 6). Having gathered sufficient information, doctors moved to the treatment phase and concluded the consultation (see Chapter 7).

This study has found that information exchanges occurred at the very beginning of some consultations and, in others, continued after the consultation had terminated. The types of information elicited were specific to different phases of the consultation. In particular, during the problem presentation stage, the participants often talked about their major concerns (see Chapter 5). In their presentation of the main concerns, patients also disclosed other types of information, such as causes or symptoms of the problem. This information established the main reason for the visit and influenced the trajectories of the interactions that followed.

Once the main concerns were established, the consultations explored these concerns in detail by looking at the information related to both the current problem and the patient's medical history (see Chapter 6). The former type of information was related to problem symptoms, causes, duration of the problem, and recovery update (if applicable). The latter was concerned with past diagnoses and treatments,

lifestyle issues, and past problems. Some information was not elicited in all consultations, depending on the visit types. For instance, 'recovery assessment' and 'past diagnoses and treatments' were skipped in the first visits in which patients had not received any treatment before, while 'duration' plus 'past diagnoses' were redundant in SDFs.

The information elicited and sought by doctors, and disclosed by patients, is presented in Table 8.1.

Table 8.1

Information Elicited and Sought by Doctors and Disclosed by Patients

Stages	Information	Doctor elicited and sought	Patient disclosed
Problem presentation	Major concern	✓	✓
History-taking and physical examination	Recovery assessment	✓	✓
	Symptoms	✓	✓
	Causes:		
	- Accidents	✓	✓
	- Daily routine	✓	✗
	- Physically-demanding tasks	✓	✓
	- Side-effects of medication	✗	✓
	- Non-adherence to a prescribed treatment regime	✗	✓
	Duration	✓	✓
	Past diagnoses and treatments:		
	- at other health centres	✓	✓
	- at the current hospital	✓	✓
	Lifestyle issues:		
	- Basic activities	✓	✓
	- Medically-related activities	✓	✓
	- Symptoms of other conditions	✓	✓
	Past problems	✓	✓
Treatment	Treatment options	✓	✓
Post-consultation	Medically-related information	✓	✓
	Medically-unrelated information	✗	✓

Throughout the corpus, all doctor elicitation listed in Table 8.1 were responded to by patients. Though the topic agendas were initiated by doctors, patients worked to give account of their actions, or disclosed further related information. In launching these strategies, patients expressed their concerns about the problem while also looking for an effective treatment from the current hospital. This disclosed

information is presented in the fourth column, 'Patient disclosed', in Table 8.1. One type of information which was not disclosed by patients (marked by ✗), however, was daily routine as causes of the problem. Even so, patients disclosed two other causes of the problem: side-effects of medication, and non-adherence to a prescribed treatment regime (marked by ✓). In addition, they also disclosed medically-unrelated information after the consultation. From the doctors' elicitors during the whole consultation in Table 8.1, patients expanded their response to provide further information. In particular, they demonstrated their knowledge of the problem (e.g., Extract 5.10), disclosed other problems (e.g., Extract 5.5), established the reasons for the visit (e.g., Extract 5.13), increased the perceived severity of the problem (e.g., Extract 5.13), or made an assessment of the problem (e.g., Extract 6.2). Moreover, there were several cases in which the information was disclosed without this being elicited (e.g., Extracts 5.13 and 6.17). Through this disclosure, patients created different trajectories for the consultations, thereby providing as much information to doctors as possible.

The types of information sought during problem presentation, history-taking and physical examination informed the treatment recommendation. In recommending treatments, doctors also obtained some information about the patient's treatment preference. In response to the doctor's treatment recommendation, patients expressed their concern about the problem as well as their expectation of effective treatment.

Even when the consultation had been closed, some doctors and patients extended it to elicit and disclose more information, which was either medically-related or medically-unrelated. Although this information emerged after the consultation, it seemed useful for doctors to set an effective treatment recommendation for patients. Remarkably, this information was initiated by both doctors and patients. For instance, in Extract 7.8, the case of doctor initiation was undertaken after the doctor and patient had reached a consensus over the treatment recommendation, and the patient was waiting for the medication to be purchased by her father. This means that the information may become irrelevant to the treatment, and seemed to be social talk only. However, this chatting can offer some insight into the patient's health and strengthen the doctor-patient relationship.

The study also showed the doctors' flexibility in the course of eliciting information. This flexibility was reflected through their management of the types of information to be elicited. In particular, there were doctors who skipped eliciting

some information that was available on the last visit. Others elicited other types of information that were not planned beforehand. Still others prolonged the consultation in order to seek further information that had been skipped during the consultation.

Looking back at the literature review in Chapter 3, most of the contemporary studies tended to restrict their focus to certain aspects of the consultation rather than considering the consultation as a whole. More particularly, in each of these studies, only a relatively small subset of the information from the consultation was examined. This included sensitive information (e.g., Wissow et al., 1994), medical information (e.g., Roter & Hall, 1987), and information related to anxiety or depression (e.g., Goto & Takemura, 2016). The present study focused on all types of information.

In short, this study provided a broader account of what types of information were elicited in a medical consultation, and also how this was done, than the majority of earlier studies.

8.2 Contributions

Theoretically, this study has extended the work of previous researchers by examining all types of information elicited by doctors and disclosed by patients during the whole medical consultation. It has added to the empirical knowledge of doctor-patient interactions in developing countries like Vietnam. The findings have shed light on various claims that have been made in previous studies on Vietnamese doctor-patient interaction, especially the pre-conception of the Vietnamese doctor-patient relationship.

This study has identified both doctors' elicitation and patients' disclosure practices during the whole consultation. It highlighted how the participants organised their talk-in-interaction to elicit and disclose various types of information across different stages of the consultation. Despite the significant importance of looking at both participants' interactions in identifying the content, context, and the interactional management (Gill & Roberts, 2012), little research has been done on this. In addition, while previous research restricted itself to only a relatively small subset of the information (e.g., Goto & Takemura, 2016; Roter & Hall, 1987; Wissow et al., 1994), this study covered all types of information, from medically-related to medically-unrelated, and psychological, social, and even personal. Moreover, the application of CA in this study has illustrated how the information-

seeking activities have been interactionally achieved by doctors and patients that previous studies on Vietnamese medical communication have not done. The findings of this study, therefore, extend the extant literature on the information-seeking activities in doctor-patient interactions generally and the doctor-patient interactions in Vietnamese setting particularly.

In addition to the theoretical contributions, the empirical findings of the present study can help to improve the medical consultations in Vietnamese public hospitals in some respects. First of all, a summary of the results will be sent to the participants and the hospital administrators in Vietnam. The interactional practices summarised in this study will hopefully raise the doctors' awareness of the importance of using appropriate elicitors in seeking information from their patients during the consultation. Once they are aware of these issues, they may try to adopt elicitors that are more appropriate; consequently, the consultation may run more quickly and more effectively. Moreover, appropriate elicitors are very likely to get appropriate responses, which help build a more comprehensive picture of the problem. In addition, the findings may also raise the doctors' awareness of the doctor-patient relationship, in which doctors sometimes silence the patients' voices through their interruptions or through not giving patients opportunity to respond. As a result of this study, doctors may put themselves in the position of patients to adjust their interactional behaviour in a way that encourages more patient participation in the consultation. Thereby, it is hoped that the consultations will be improved to some extent towards true patient-centredness. This improvement in consultations is, in turn, expected to enhance the quality of medical care as a result.

There has been an increasing turn to focus on how doctors talk to patients in the medical training of doctors. Yet we know that this is based on a reflective rather than dialogical understanding of communication. Therefore, the findings of this empirical study could be used as a resource for the training of medical students in how to interact with patients. The recorded medical consultations in this study could be good reflections of real conduct of both doctors and patients in actual interactions, which significantly contribute to improving students' medical communication skills. Hence, this study helps enhance the quality of medical care, especially in the cultural context of Vietnam.

As discussed in Section 8.1, some of the findings of this study are similar to those of previous research. This means that the results of this study may be used as a

reference source for the investigation of information-seeking activities in doctor-patient interaction in other cultures. Moreover, living in an environment of globalisation and intercultural cooperation in which more and more Vietnamese people have recently migrated overseas for study and family reunion (Vietnamese Bureau of Consular Affairs, 2011), and increasing numbers of foreigners have come to Vietnam (General Statistics Office of Vietnam, 2018), the findings of this study may help the non-Vietnamese doctors and patients understand how the Vietnamese patients and doctors interact during medical consultations. This may limit any misinterpretation during consultations and enhance medical outcomes to some extent.

8.3. Limitations and suggestions for further research

The study has a number of limitations in terms of data collection. First, as audio recording is unable to capture the participants' non-verbal behaviour, some forms of elicitation and disclosure (e.g., a nod or headshake; see Hutchby & Wooffitt, 1998; Williams et al., 2013) were not captured in this study. Therefore, future studies could consider using video recording as the main data collection instrument, as it may be that there are cultural differences in non-verbal behaviour that were missed in this study. Second, as H. T. T. Trương (personal communication, June 20th, 2016) revealed, the doctors in the consulting rooms often conducted a more thorough examination on consulting patients than on the other two types (i.e., inpatients and outpatients). Future studies should compare the doctors' consultations with these groups of patients to identify the differences. Third, this study only examined hospitals at a provincial level. The interactional patterns of doctor-patient communication in this study may not hold true at lower or higher levels of the medical system in Vietnam, given that the information-seeking practices may vary depending on the institutional context. Hence, future studies should focus on doctor-patient interactions in hospitals at communal, district, and national levels.

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Nguyễn, H. T. L. (November, 2017). *Seeking information in a medical consultation: Problem presentation*. Paper presented at The Applied Linguistics Conference (ALANZ/ALAA/ALTAANZ): Applied Linguistics in the New Millennium: Multiple Theories, Pathways, and Practices, Auckland, New Zealand.

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Appendices

Appendix A: Inventory of participating doctors

Table A.1

Details of Participating Doctors at Hospital A

No	Code	Gender	Age category	Work experience (until June 2016)		Place of medical training
				Years	Months	
1.	A – BS – 01	M	51 – 55	25	8	Vietnam
2.	A – BS – 02	M	56 – 60	3	3	Vietnam

Table A.2

Details of Participating Doctors at Hospital B

No	Code	Gender	Age category	Work experience (until July 2016)		Place of medical training
				Years	Months	
1.	B – BS – 01	F	51 – 55	25	10	Vietnam
2.	B – BS – 02	M	51 – 55	23	5	Vietnam
3.	B – BS – 03	M	46 – 50	11	7	Vietnam
4.	B – BS – 04	M	51 – 55	29	5	Vietnam & France
5.	B – BS – 05	M	31 – 35	8	10	Vietnam
6.	B – BS – 06	M	41 – 45	16	0	Vietnam
7.	B – BS – 07	M	36 – 40	13	8	Vietnam
8.	B – BS – 08	M	36 – 40	14	9	Vietnam
9.	B – BS – 09	M	36 – 40	13	8	Vietnam
10.	B – BS – 10	M	36 – 40	14	0	Vietnam
11.	B – BS – 11	F	46 – 50	20	7	Vietnam
12.	B – BS – 12	M	46 – 50	13	8	Vietnam
13.	B – BS – 13	F	26 – 30	0	3	Vietnam

Appendix B: Inventory of participating patients

Table B.1

Details of Participating Patients

Patients' demographics		Hospital A (N=16)	Hospital B (N=50)	Number	Percentage
Gender	male	9	17	26	39.4
	female	7	33	40	60.6
Age category	20 – 30	0	3	3	4.6
	31 – 40	0	3	3	4.6
	41 – 50	3	8	11	16.7
	51 – 60	1	8	9	13.6
	61 – 70	4	12	16	24.2
	71 – 80	6	9	15	22.7
	81 – 90	2	7	9	13.6
Education	illiterate	0	2	2	3.0
	mass	0	1	1	1.5
	primary	8	18	26	39.4
	secondary	1	8	9	13.6
	high school	6	8	14	21.2
	vocational / technical training	0	2	2	3.0
	university	1	11	12	18.2
Place of residence	city	7	19	26	39.4
	town	5	21	26	39.4
	village	4	10	14	21.2
Occupation	white-collar worker	5	17	22	33.3
	blue-collar worker	11	33	44	66.7
Visit type	first visit	3	32	35	53.0
	SDF	3	6	9	13.6
	DDF	10	12	22	33.4

Appendix C: Participant information form for doctors (English version)

Participant Information for USQ Research Project

Doctor

Project Details	
Title of the project:	**Vietnamese doctor-patient communication**
Human Research Ethics Approval Number:	H16REA115

Research Team Contact Details	
Principal Investigator Details	**Supervisor Details**
Ms. Huong Thi Linh Nguyen	1. Associate Professor Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Telephone: +61 7 4631 1618	Telephone: +61 7 3470 4513
Mobile: +61 414 864205 (Australia)	2. Dr Gavin Austin
+84 935 399 383 (Vietnam)	Email: Gavin.Austin@usq.edu.au
	Telephone: +61 7 4631 1934

Description

This project is being undertaken as part of Huong Thi Linh Nguyen's PhD project. It aims to understand how doctors and patients communicate during medical consultations. The doctors to be recruited are about 30 general practitioners working at the Consultation and General Practice Units.

The research team requests your assistance because this project cannot be completed without audio-recorded data from, and demographic information about, Vietnamese doctors. The recordings of the consultations will contribute to our understanding of how information is exchanged in these consultations, while the demographic information will be used to examine how this information influences each participant's communication.

Participation

Your participation will involve: (1) completion of a questionnaire that will take approximately five minutes of your time (items in the questionnaire will include only demographic information), and (2) audio-recordings of your medical visits with

different patients. Each consultation will involve only you and one patient, and no-one else (e.g., the patient's family members). Before each consultation takes place, a member of the research team will go into the room to put the audio-recorder in a convenient place, and she will leave before you and the patient enter the room. The researcher will not be present in the consulting room at the time of recording in order to minimise any distraction or discomfort to you or the patient. Once the patient enters the room, you will ask them if they have given consent to participate in the project prior to the recording. You will operate the audio-recorder.

Your participation in this project is entirely voluntary. If you do not wish to take part, you are not obliged to. You are free to switch off the audio-recorder at any time during the recording session. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that any data collected about you be destroyed. If you do wish to withdraw from this project or withdraw data collected about you, please contact the Research Team (for their contact details, please see the top of this form).

Before you consent to participate, you may discuss with others the details of this project or your decision. Whether or not you take part, or take part and then withdraw, will in no way impact your current or future relationship with the hospital or the University of Southern Queensland.

Expected Benefits

The research findings can be used by you or the hospital to improve the quality of the therapeutic service that you offer to clients.

Risks

You may be so busy that you do not have time to fill in the questionnaire. We will ensure that the questionnaire only takes 5 minutes to complete, with only closed-ended items related to your demographic information. You can complete the questionnaire after your working hours or when convenient, and at any place of your choice. If you feel anxious at any time during the recording, you may switch off the recorder without explanation or adverse consequences.

Other information

The project will be carried out in accordance with the National Statement on Ethical Conduct in Human Research. All comments and responses will be treated

confidentially unless required by law. As questionnaires and audio-recordings will be used in this project, please note the following:

- You will not have the opportunity to listen to the recordings of any of your consultations prior to their final inclusion in the project.

- Your data may be used in the future for other research in the area of medical communication. You may participate in the current project and decline to have your data used in any future ones.

- A copy of the 'results' sections of any publications based on the findings of this project (in future academic publications and in a doctoral dissertation) can be sent to you upon request.

- Only the research team will have access to the data. Any translators outside the investigative team will sign a confidentiality agreement before the translation is made.

- It is not possible to participate in the project without filling out the questionnaires and being recorded.

Any data collected as part of this project will be stored securely as per University of Southern Queensland's Research Data Management policy.

Consent to Participate

We would like to ask you to sign a written consent form (enclosed) to confirm your agreement to participate in this project. Please return your signed consent form to Huong Thi Linh Nguyen prior to filling in the questionnaire and participating in the recordings.

Questions or Further Information about the Project

If you have any questions or if you would like further information about this project, please refer to the Research Team Contact Details at the top of the form.

Concerns or Complaints Regarding the Conduct of the Project

If you have any concerns or complaints about the ethical conduct of the project, you may contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au. The Ethics Coordinator is not connected with the research project, and can facilitate a resolution to your concern in an unbiased manner.

Thank you for taking the time to help with this research project. Please keep this sheet for your information.

Appendix D: Participant information form for doctors (Vietnamese version)

Thông tin dành cho người tham gia nghiên cứu của Đại học USQ

Bác sĩ

Thông tin dự án	
Tên dự án:	**Giao tiếp giữa bác sĩ và bệnh nhân Việt Nam**
Số quyết định:	H16REA115

Thông tin nhóm nghiên cứu	
Người nghiên cứu chính	**Giáo viên hướng dẫn**
Nguyễn Thị Linh Hương	1. PGS.TS. Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Điện thoại: +61 7 4631 1618	Điện thoại: +61 7 3470 4513
Di động: +61 414 864 205 (Úc)	2. TS. Gavin Austin
+84 935 399 383 (Việt nam)	Email: Gavin.Austin@usq.edu.au
	Điện thoại: +61 7 4631 1934

Mô tả dự án

Đây là dự án nghiên cứu bậc Tiến sĩ của Nguyễn Thị Linh Hương. Dự án nghiên cứu giao tiếp giữa bác sĩ và bệnh nhân trong quá trình khám chữa bệnh. Các bác sĩ tham gia vào dự án gồm khoảng 30 bác sĩ đang công tác tại các khoa, phòng.

Nhóm nghiên cứu cần sự trợ giúp của Quý vị vì dự án này không thể hoàn thành nếu không thu âm ca khám bệnh và thông tin cá nhân của Bác sĩ. Thu âm nhằm tìm hiểu giao tiếp diễn ra như thế nào trong quá trình khám bệnh, và thông tin cá nhân giúp đánh giá ảnh hưởng của tuổi tác và giới tính của bác sĩ đối với giao tiếp của họ.

Chi tiết quá trình tham gia

Quý vị sẽ hoàn thành bản khảo sát khoảng 5 phút. Nội dung bản khảo sát chủ yếu về thông tin cá nhân. Sau đó chúng tôi sẽ thu âm các ca khám bệnh của Quý vị với các bệnh nhân khác nhau. Mỗi ca khám bệnh chỉ có một bác sĩ và một bệnh nhân, không có người thứ ba (ví dụ, người thân của bệnh nhân). Trước khi thu âm, thành viên nhóm nghiên cứu sẽ vào phòng khám để máy thu âm ở vị trí cố định, sau đó sẽ ra

ngoài trước khi Quý vị và bệnh nhân vào. Nhóm nghiên cứu sẽ không có mặt trong phòng khám tại thời điểm thu âm nhằm tránh gây xao lãng cho người tham gia. Khi bệnh nhân vào phòng khám, Quý vị sẽ hỏi xem họ có đồng ý tham gia nghiên cứu trước khi tiến hành thu âm. Quý vị sẽ điều khiển máy thu âm.

Tham gia khảo sát này là hoàn toàn tự nguyện. Quý vị không bị bắt buộc nếu không muốn tham gia. Quý vị có thể dừng thu âm bất kỳ lúc nào trong quá trình khám bệnh. Nếu Quý vị đã đồng ý tham gia nhưng sau đó thay đổi ý định, Quý vị có thể ngừng tham gia bất kỳ lúc nào. Quý vị có thể yêu cầu hủy bỏ dữ liệu của Quý vị đã được thu thập. Nếu Quý vị muốn rút khỏi dự án xin thông báo với nhóm nghiên cứu (theo thông tin cung cấp ở trên).

Quý vị có thể thảo luận nội dung dự án hoặc quyết định của Quý vị với bất kỳ ai trước khi đồng ý tham gia. Quyết định tham gia, không tham gia, hoặc tham gia sau đó rút khỏi dự án, sẽ không ảnh hưởng đến quan hệ hiện tại hay tương lai của Quý vị với bệnh viện hay với trường Đại học Southern Queensland.

Lợi ích

Quý vị và bệnh viện có thể tham khảo kết quả nghiên cứu để nâng cao chất lượng dịch vụ y tế cung cấp cho bệnh nhân.

Bất lợi

Quý vị có thể không có thời gian để điền khảo sát. Tuy nhiên khảo sát chỉ mất 5 phút, với các câu hỏi chọn lựa về thông tin cá nhân của Quý vị. Quý vị có thể hoàn thành khảo sát ở bất kỳ nơi nào, sau giờ làm việc, hoặc khi nào rảnh. Nếu cảm thấy căng thẳng trong quá trình thu âm, Quý vị có thể dừng thu âm bất kỳ lúc nào không cần phải giải thích lý do.

Thông tin khác

Dự án sẽ được tiến hành theo Quy định quốc gia về chuẩn mực đạo đức trong nghiên cứu khoa học liên quan đến con người. Mọi dữ liệu của người tham gia sẽ được bảo mật theo quy định. Vì dự án này sẽ sử dụng nội dung thu âm và bản khảo sát của Quý vị, xin Quý vị lưu ý những điểm sau:

- Quý vị sẽ không được nghe lại nội dung phần thu âm của bất kỳ ca khám bệnh nào trước khi chúng được chọn làm dữ liệu chính thức của dự án;

- Dữ liệu của Quý vị có thể được dùng trong các nghiên cứu về giao tiếp y tế trong tương lai. Quý vị có thể tham gia vào nghiên cứu này và từ chối sử dụng dữ liệu cho các nghiên cứu sau này.

- Bản sao kết quả nghiên cứu được xuất bản (các xuất bản trong tương lai hoặc luận án tiến sĩ) sẽ được gửi cho Quý vị theo yêu cầu.

- Chỉ thành viên nhóm nghiên cứu mới được tiếp cận dữ liệu. Bất kỳ thông dịch viên nào không thuộc nhóm nghiên cứu sẽ phải ký biên bản thỏa thuận bảo mật thông tin trước khi tiến hành thông dịch; và

- Không thể tham gia vào dự án nếu không thu âm và điền bản khảo sát.

Dữ liệu dùng cho dự án sẽ được lưu trữ bảo mật theo quy định về quản lý dữ liệu nghiên cứu của trường đại học Southern Queensland.

Cam kết tham gia

Nếu đồng ý tham gia xin Quý vị ký vào bản cam kết (đính kèm) để xác nhận và chuyển tờ cam kết lại cho Nguyễn Thị Linh Hương trước khi tiến hành thu âm và/hoặc khảo sát.

Giải đáp thắc mắc

Nếu Quý vị có bất kỳ thắc mắc nào liên quan đến dự án xin liên hệ với nhóm nghiên cứu theo thông tin ở trên.

Khiếu nại về vấn đề đạo đức của dự án

Nếu Quý vị có khiếu nại gì liên quan đến vấn đề đạo đức của dự án có thể liếc lạc với Điều phối viên ban xét duyệt nội quy đạo đức nghiên cứu khoa học của trường Đại học Southern Queensland qua số điện thoại (07) 4631 2690 hoặc email ethics@usq.edu.au. Điều phối viên này không phải là thành viên của nhóm nghiên cứu nên có thể giải đáp thắc mắc của Quý vị một cách khách quan.

Cảm ơn Quý vị đã dành thời gian cho dự án. Quý vị có thể giữ lại bản thông tin này

Appendix E: Consent form for doctors (English version)

Consent Form for USQ Research Project

Doctor

Project Details	
Title of the project:	**Vietnamese doctor-patient communication**
Human Research Ethics Approval Number:	H16REA115

Research Team Contact Details	
Principal Investigator Details	**Supervisor Details**
Ms Huong Thi Linh Nguyen	1. Associate Professor Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Telephone: +61 7 4631 1618	Telephone: +61 7 3470 4513
Mobile: +61 414 864205 (Australia)	2. Dr Gavin Austin
+84 935 399 383 (Vietnam)	Email: Gavin.Austin@usq.edu.au
	Telephone: +61 7 4631 1934

Statement of Consent

By signing below, I am indicating that I:

- Have read and understood the information document regarding this project.

- Have had any questions answered to my satisfaction.

- Understand that if I have any additional questions, I can contact the research team.

- Understand that the consultations will be audio-recorded.

- Understand that I will not be provided with a copy of the transcript of the communication for my perusal and endorsement prior to inclusion of this data in the project.

- Understand that I am free to cease the audio-recording at any time while recording.

- Understand that I am free to withdraw at any time, without comment or penalty.

- Understand that I can contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au if I do have any concerns or complaints about the ethical conduct of this project.

- Am over 18 years of age.

- Consent to my recordings and questionnaire being used for future research projects in the area of medical communication.

If you **do not want** your recordings and questionnaire used for future research projects, please initial here ……………………………………………………………..

- Agree to participate in:

Questionnaire: ☐ Yes   ☐ No

Audio-recording: ☐ Yes   ☐ No

Participant Name	

Participant Signature	

Date	

If you wish to receive a summary of the results, please provide your email/mailing address: _____

Please return this sheet to a Research Team member before the study takes place.

Appendix F: Consent form for doctors (Vietnamese version)

Cam kết tham gia nghiên cứu của đại học USQ

Bác sĩ

Thông tin dự án	
Tên dự án:	**Giao tiếp giữa bác sĩ và bệnh nhân Việt Nam**
Số quyết định:	H16REA115

Thông tin nhóm nghiên cứu

Người nghiên cứu chính	**Cán bộ hướng dẫn**
Nguyễn Thị Linh Hương	1. PGS.TS. Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Điện thoại: +61 7 4631 1618	Điện thoại: +61 7 3470 4513
Di động: +61 414 864 205 (Úc)	2. TS. Gavin Austin
+84 935 399 383 (Việt nam)	Email: Gavin.Austin@usq.edu.au
	Điện thoại: +61 7 4631 1934

Điều khoản cam kết

Bằng việc ký tên dưới đây, tôi xác nhận rằng tôi:

- Đã đọc và hiểu các thông tin về dự án.

- Đã được trả lời các câu hỏi đầy đủ.

- Hiểu rằng tôi có thể hỏi nhóm nghiên cứu bất kỳ câu hỏi nào liên quan đến dự án.

- Hiểu rằng ca khám bệnh sẽ được thu âm.

- Hiểu rằng tôi sẽ không được cung cấp bản phiên âm của ca khám bệnh trước khi nó được chọn làm dữ liệu chính thức của dự án.

- Hiểu rằng tôi có thể dừng thu âm bất kỳ lúc nào trong quá trình thu âm.

- Hiểu rằng tôi có thể ngừng tham gia bất kỳ lúc nào không cần giải thích lý do và cũng không bị ảnh hưởng gì.

- Hiểu rằng nếu tôi thấy thắc mắc hoặc khiếu nại về hành vi đạo đức của dự án này, tôi có thể liên lạc với điều phối viên ban xét duyệt nội quy đạo đức nghiên cứu khoa học của trường Đại học Southern Queensland qua số điện thoại (07) 4631 2690 hoặc email ethics@usq.edu.au.

- Hơn 18 tuổi.

- Đồng ý dữ liệu của tôi có thể được dùng cho các dự án về giao tiếp y tế trong tương lai

Nếu Quý vị **không muốn** dữ liệu của mình được dùng cho các dự án nghiên cứu trong tương lai, xin ký nháy ở đây ……………………………………………….

- Đồng ý tham gia:

Khảo sát: ☐ Có   ☐ Không

Thu âm: ☐ Có   ☐ Không

Tên người tham gia

Chữ ký người tham gia

Ngày tháng năm

Nếu Quý vị muốn nhận bản tóm tắt kết quả nghiên cứu, xin cung cấp địa chỉ liên lạc (hoặc email): _____

Xin vui lòng chuyển giấy cam kết này cho thành viên nhóm nghiên cứu trước khi tham gia

Appendix G: Questionnaire for doctors (English version)

DOCTOR QUESTIONNAIRE

Participant's code:…….

(Please leave this section blank)

Title of the project: **Vietnamese doctor-patient communication**

Please put a tick ☑ where appropriate

1. Your gender:

☐ Male   ☐ Female

2. Which age category do you belong to?

☐ 20 – 25   ☐ 46 – 50

☐ 26 – 30   ☐ 51 – 55

☐ 31 – 35   ☐ 56 – 60

☐ 36 – 40   ☐ 61 – 65

☐ 41 – 45   ☐ 66 – 70

Other: (please specify) _____

3. When did you start working in medicine? _____

4. Where did you train in medicine?

☐ Vietnam

☐ Overseas (please specify the country): _____

Thank you for taking the time to complete this questionnaire!

Appendix H: Questionnaire for doctors (Vietnamese version)

BẢN KHẢO SÁT BÁC SĨ

Mã số:.......

(Xin để trống phần này)

Tên dự án: **Giao tiếp giữa bác sĩ và bệnh nhân Việt Nam**

Xin đánh dấu ☑ vào ô phù hợp

1. Giới tính của Quý vị:

☐ Nữ

☐ Nam

2. Quý vị nằm trong nhóm tuổi nào?

☐ 20 – 25   ☐ 46 – 50

☐ 26 – 30   ☐ 51 – 55

☐ 31 – 35   ☐ 56 – 60

☐ 36 – 40   ☐ 61 – 65

☐ 41 – 45   ☐ 66 – 70

Khác: (xin nêu rõ) _____

3. Quý vị vào ngành y ngày tháng năm nào?:_____

4. Quý vị được đào tạo chuyên môn y khoa ở đâu?

☐ Việt nam

☐ Nước ngoài (xin nêu rõ quốc gia): _____

Cảm ơn quý vị đã dành thời gian hoàn thành bản khảo sát này!

Appendix I: Participant information form for patients (English version)

Participant Information for USQ Research Project

Patient

Project Details	
Title of the project:	**Vietnamese doctor-patient communication**
Human Research Ethics Approval Number:	H16REA115

Research Team Contact Details	
Principal Investigator Details	**Supervisor Details**
Ms Huong Thi Linh Nguyen	1. Associate Professor Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Telephone: +61 7 4631 1618	Telephone: +61 7 3470 4513
Mobile: +61 414 864205 (Australia)	2. Dr Gavin Austin
+84 935 399 383 (Vietnam)	Email: Gavin.Austin@usq.edu.au
	Telephone: +61 7 4631 1934

Description

This project is being undertaken as part of Huong Thi Linh Nguyen's PhD project. It aims to understand how doctors and patients communicate during medical consultations. The patients to be recruited are about 120 adult patients (from 20 to 90 years of age) that intend to see the doctor alone (i.e., without any relatives) at the Consultation and General Practice Units.

The research team requests your assistance because this project cannot be completed without audio-recorded data from, and demographic information about, Vietnamese patients. The recordings of the consultations will contribute to our understanding of how information is exchanged in these consultations, while the demographic information will be used to examine how this information influences each participant's communication.

Participation

Your participation will involve: (1) completion of a questionnaire that will take approximately five minutes of your time (items in the questionnaire will include only demographic information), and (2) your communication with the doctor during the

consultation to be recorded. The consultation will involve only you and your doctor, and no-one else (e.g., your family members). Before each consultation takes place, a member of the research team will go into the room to put the audio-recorder in a convenient place, and she will leave before the doctor and you enter the room. The doctor will operate the audio-recorder. The researcher will not be present in the room at the time of recording, in order to minimise any distraction or discomfort to you or the doctor.

Your participation in this project is entirely voluntary. If you do not wish to take part, you are not obliged to. You are free to ask the doctor to switch off the audio-recorder at any time during the recording session. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that any data collected about you be destroyed. If you do wish to withdraw from this project or withdraw data collected about you, please contact the Research Team (for their contact details, please see the top of this form).

Before you consent to participate, you may discuss with others the details of this project or your decision to participate. Whether or not you take part, or take part and then withdraw, will in no way impact your current or future relationship with the hospital or the University of Southern Queensland, the doctors, or any other services at this hospital.

Expected Benefits

It is possible that the research findings will be of immediate benefit to you as they can be used to improve the quality of the therapeutic service that you receive at the current hospital.

Risks

You may have little time to fill in the questionnaire. We will ensure that the questionnaire only takes 5 minutes to complete, with only closed-ended items related to demographic information. You can complete the questionnaire while you are in the waiting room or at any place of your choice. If you feel anxious at any time during the recording, you may ask the doctor to switch off the audio-recorder without explanation or adverse consequences.

Other information

The project will be carried out in accordance with the National Statement on Ethical Conduct in Human Research. All comments and responses will be treated

confidentially unless required by law. As questionnaires and audio recordings will be used in this project, please note the following:

- You will not have the opportunity to listen to the recording prior to its final inclusion in the project.

- Your data may be used in the future for other research in the area of medical communication. You may participate in the current project, and decline to have your data used in any future ones.

- A copy of the 'results' section of any publications based on the findings of this project (in future academic publications and in a doctoral dissertation) can be sent to you upon request.

- Only the research team will have access to the data. Any translators outside the investigative team will sign a confidentiality agreement before the translation is made.

- It is not possible to participate in the project without filling out the questionnaires and being recorded.

Any data collected as a part of this project will be stored securely as per University of Southern Queensland's Research Data Management policy.

Consent to Participate

We would like to ask you to sign a written consent form (enclosed) to confirm your agreement to participate in this project. Please return your signed consent form to a member of the Research Team prior to filling in the questionnaire and participating in the recording.

Questions or Further Information about the Project

If you have any questions or if you would like further information about this project, please refer to the Research Team Contact Details at the top of the form.

Concerns or Complaints Regarding the Conduct of the Project

If you have any concerns or complaints about the ethical conduct of the project, you may contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au. The Ethics Coordinator is not connected with the research project, and can facilitate a resolution to your concern in an unbiased manner.

Thank you for taking the time to help with this research project. Please keep this sheet for your information.

Appendix J: Participant information form for patients (Vietnamese version)

Thông tin dành cho người tham gia nghiên cứu của Đại học USQ

Bệnh nhân

Thông tin dự án	
Tên dự án:	**Giao tiếp giữa bác sĩ và bệnh nhân Việt Nam**
Số quyết định:	H16REA115

Thông tin nhóm nghiên cứu	
Người nghiên cứu chính	**Giáo viên hướng dẫn**
Nguyễn Thị Linh Hương	1. PGS.TS. Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Điện thoại: +61 7 4631 1618	Điện thoại: +61 7 3470 4513
Di động: +61 414 864 205 (Úc)	2. TS. Gavin Austin
+84 935 399 383 (Việt nam)	Email: Gavin.Austin@usq.edu.au
	Điện thoại: +61 7 4631 1934

Mô tả dự án

Đây là dự án nghiên cứu bậc Tiến sĩ của Nguyễn Thị Linh Hương. Dự án nghiên cứu giao tiếp giữa bác sĩ và bệnh nhân trong quá trình khám chữa bệnh. Dự án sẽ mời khoảng 120 bệnh nhân (từ 20 đến 90 tuổi) tới khám bệnh một mình (không có người nhà) tại các khoa, phòng.

Nhóm nghiên cứu cần sự trợ giúp của Quý vị vì dự án này không thể hoàn thành nếu không thu âm ca khám bệnh và thông tin cá nhân của bệnh nhân. Thu âm nhằm tìm hiểu giao tiếp diễn ra như thế nào trong quá trình khám bệnh, và thông tin cá nhân giúp đánh giá ảnh hưởng của tuổi tác, giới tính, và địa vị xã hội của bệnh nhân đối với giao tiếp của họ.

Chi tiết quá trình tham gia

Quý vị sẽ hoàn thành bản khảo sát khoảng 05 phút. Nội dung bản khảo sát chủ yếu về thông tin cá nhân. Sau đó chúng tôi sẽ thu âm ca khám bệnh của Quý vị với bác sĩ. Ca khám bệnh chỉ có một bác sĩ và một bệnh nhân, không có người thứ ba (ví dụ, người nhà của Quý vị). Trước khi thu âm, thành viên nhóm nghiên cứu sẽ vào phòng

khám để máy thu âm ở vị trí cố định, sau đó sẽ ra ngoài trước khi bác sĩ và Quý vị vào. Bác sĩ sẽ điều khiển máy thu âm. Nhóm nghiên cứu sẽ không có mặt trong phòng khám tại thời điểm thu âm nhằm tránh gây xao lãng cho Quý vị và bác sĩ.

Tham gia khảo sát này là hoàn toàn tự nguyện. Quý vị không bị bắt buộc nếu không muốn tham gia. Quý vị có thể yêu cầu bác sĩ dừng thu âm bất kỳ lúc nào trong quá trình khám bệnh. Nếu Quý vị đã đồng ý tham gia nhưng sau đó thay đổi ý định, Quý vị có thể ngừng tham gia bất kỳ lúc nào. Quý vị có thể yêu cầu hủy bỏ dữ liệu của Quý vị đã được thu thập. Nếu Quý vị muốn rút khỏi dự án xin thông báo với nhóm nghiên cứu (theo thông tin cung cấp ở trên).

Quý vị có thể thảo luận nội dung dự án hoặc quyết định của Quý vị với người nhà hoặc bất kỳ ai trước khi đồng ý tham gia. Quyết định tham gia, không tham gia, hoặc tham gia sau đó rút khỏi dự án, sẽ không ảnh hưởng đến quan hệ hiện tại hay tương lai của Quý vị với trường Đại học Southern Queensland, bác sĩ, các khoa phòng, hay với các dịch vụ khác của bệnh viện.

Lợi ích

Nghiên cứu này có thể mang lợi trực tiếp cho Quý vị vì kết quả nghiên cứu sẽ được áp dụng nhằm nâng cao chất lượng dịch vụ y tế cung cấp cho Quý vị tại bệnh viện này.

Bất lợi

Quý vị có thể không có thời gian để điền vào bản khảo sát. Tuy nhiên khảo sát chỉ mất 5 phút, với các câu hỏi chọn lựa về thông tin cá nhân của Quý vị. Quý vị có thể hoàn thành bản khảo sát ở phòng đợi hoặc bất kỳ nơi nào. Nếu cảm thấy căng thẳng trong quá trình thu âm, Quý vị có thể yêu cầu bác sĩ dừng thu âm bất kỳ lúc nào không cần phải giải thích lý do.

Thông tin khác

Dự án sẽ được tiến hành theo Quy định quốc gia về chuẩn mực đạo đức trong nghiên cứu khoa học liên quan đến con người. Mọi dữ liệu của người tham gia sẽ được bảo mật theo quy định. Vì dự án này sẽ sử dụng nội dung thu âm và bản khảo sát của Quý vị, xin Quý vị lưu ý những điểm sau:

- Quý vị sẽ không được nghe lại nội dung phần thu âm của bất kỳ ca khám bệnh nào trước khi chúng được chọn làm dữ liệu chính thức của dự án;

- Dữ liệu của Quý vị có thể được dùng trong các nghiên cứu về giao tiếp y tế trong tương lai. Quý vị có thể tham gia vào nghiên cứu này và từ chối sử dụng dữ liệu cho các nghiên cứu sau này.

- Bản sao kết quả nghiên cứu được xuất bản (các xuất bản trong tương lai hoặc luận án tiến sĩ) sẽ được gửi cho Quý vị theo yêu cầu.

- Chỉ thành viên nhóm nghiên cứu mới được tiếp cận dữ liệu. Bất kỳ thông dịch viên nào không thuộc nhóm nghiên cứu sẽ phải ký biên bản thỏa thuận bảo mật thông tin trước khi tiến hành thông dịch; và

- Không thể tham gia vào dự án nếu không thu âm và điền bản khảo sát.

Dữ liệu dùng cho dự án sẽ được lưu trữ bảo mật theo quy định về quản lý dữ liệu nghiên cứu của trường đại học Southern Queensland.

Cam kết tham gia

Nếu đồng ý tham gia xin Quý vị ký vào bản cam kết (đính kèm) để xác nhận và chuyển bản cam kết lại cho Nguyễn Thị Linh Hương trước khi tiến hành thu âm và/hoặc khảo sát.

Giải đáp thắc mắc

Nếu Quý vị có bất kỳ thắc mắc nào liên quan đến dự án xin liên hệ với nhóm nghiên cứu theo thông tin ở trên.

Khiếu nại về vấn đề đạo đức của dự án

Nếu Quý vị có khiếu nại gì liên quan đến vấn đề đạo đức của dự án có thể liêc lạc với Điều phối viên ban xét duyệt nội quy đạo đức nghiên cứu khoa học của trường Đại học Southern Queensland qua số điện thoại (07) 4631 2690 hoặc email ethics@usq.edu.au. Điều phối viên này không phải là thành viên của nhóm nghiên cứu nên có thể giải đáp thắc mắc của Quý vị một cách khách quan.

Cảm ơn Quý vị đã dành thời gian cho dự án. Quý vị có thể giữ lại bản thông tin này

Appendix K: Consent form for patients (English version)

Consent Form for USQ Research Project

Patient

Project Details	
Title of the project:	**Vietnamese doctor-patient communication**
Human Research Ethics Approval Number:	H16REA115

Research Team Contact Details	
Principal Investigator Details	**Supervisor Details**
Ms Huong Thi Linh Nguyen	1. Associate Professor Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Telephone: +61 7 4631 1618	Telephone: +61 7 3470 4513
Mobile: +61 414 864205 (Australia)	2. Dr Gavin Austin
+84 935 399 383 (Vietnam)	Email: Gavin.Austin@usq.edu.au
	Telephone: +61 7 4631 1934

Statement of Consent

By signing below, I am indicating that I:

- Have read and understood the information document regarding this project.

- Have had any questions answered to my satisfaction.

- Understand that if I have any additional questions, I can contact the research team.

- Understand that the consultation will be audio-recorded.

- Understand that I will not be provided with a copy of the transcript of the communication for my perusal and endorsement prior to inclusion of this data in the project.

- Understand that I am free to ask the doctor to cease the audio-recording at any time while recording.

- Understand that I am free to withdraw at any time, without comment or penalty.

- Understand that I can contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au if I do have any concern or complaint about the ethical conduct of this project.

- Am over 18 years of age.

- Consent to my recording and questionnaire being used for future research projects in the area of medical communication.

If you **do not want** your recording and questionnaire used for future research projects, please initial here: ………………………………………………………………

- Agree to participate in:

Questionnaire: ☐ Yes   ☐ No

Audio-recording: ☐ Yes   ☐ No

Participant Name	
Participant Signature	
Date	

If you wish to receive a summary of the results, please provide your email/mailing address: _____

Please return this sheet to a Research Team member before the study takes place.

Appendix L: Consent form for patients (Vietnamese version)

Cam kết tham gia nghiên cứu của đại học USQ

Bệnh nhân

Thông tin dự án	
Tên dự án:	**Giao tiếp giữa bác sĩ và bệnh nhân Việt Nam**
Số quyết định:	H16REA115

Thông tin nhóm nghiên cứu	
Người nghiên cứu chính	**Cán bộ hướng dẫn**
Nguyễn Thị Linh Hương	1. PGS.TS. Shirley O'Neill
Email: huong.nguyen@usq.edu.au	Email: Shirley.ONeill@usq.edu.au
Điện thoại: +61 7 4631 1618	Điện thoại: +61 7 3470 4513
Di động: +61 414 864 205 (Úc)	2. TS. Gavin Austin
+84 935 399 383 (Việt nam)	Email: Gavin.Austin@usq.edu.au
	Điện thoại: +61 7 4631 1934

Điều khoản cam kết

Bằng việc ký tên dưới đây, tôi xác nhận rằng tôi:

- Đã đọc và hiểu các thông tin về dự án.

- Đã được trả lời các câu hỏi đầy đủ.

- Hiểu rằng tôi có thể hỏi nhóm nghiên cứu bất kỳ câu hỏi nào liên quan đến dự án.

- Hiểu rằng ca khám bệnh sẽ được thu âm.

- Hiểu rằng tôi sẽ không được cung cấp bản phiên âm của ca khám bệnh trước khi nó được chọn làm dữ liệu chính thức của dự án.

- Hiểu rằng tôi có thể yêu cầu bác sĩ dừng thu âm bất kỳ lúc nào trong quá trình thu âm.

- Hiểu rằng tôi có thể ngừng tham gia bất kỳ lúc nào không cần giải thích lý do và cũng không bị ảnh hưởng gì.

- Hiểu rằng nếu tôi thấy thắc mắc hoặc khiếu nại về hành vi đạo đức của dự án này, tôi có thể liên lạc với điều phối viên ban xét duyệt nội quy đạo đức nghiên cứu khoa học của trường Đại học Southern Queensland qua số điện thoại (07) 4631 2690 hoặc email ethics@usq.edu.au.

- Hơn 18 tuổi.

- Đồng ý dữ liệu của tôi có thể được dùng cho các dự án về giao tiếp y tế trong tương lai

Nếu Quý vị **không muốn** dữ liệu của mình được dùng cho các dự án nghiên cứu trong tương lai, xin ký nháy ở đây: ....……………………………………………...

- Đồng ý tham gia:

Khảo sát: ☐ Có   ☐ Không

Thu âm: ☐ Có   ☐ Không

Tên người tham gia	
Chữ ký người tham gia	
Ngày tháng năm	

Nếu Quý vị muốn nhận bản tóm tắt kết quả nghiên cứu, xin cung cấp địa chỉ liên lạc (hoặc email): _____

Xin vui lòng chuyển giấy cam kết này cho thành viên nhóm nghiên cứu trước khi tham gia

Appendix M: Questionnaire for patients (English version)

PATIENT QUESTIONNAIRE

Participant's code:……..

(Please leave this section blank)

Title of the project: **Vietnamese doctor-patient communication**

Please put a tick ☑ where appropriate

1. Your gender:

☐ Female   ☐ Male

☐ Undisclosed

2. Which age category do you belong to?

☐ 20 - 25   ☐ 56 – 60

☐ 26 - 30   ☐ 61 – 65

☐ 31 - 35   ☐ 66 – 70

☐ 36 - 40   ☐ 71 – 75

☐ 41 – 45   ☐ 76 – 80

☐ 46 - 50   ☐ 81 – 85

☐ 51 - 55   ☐ 86 – 90

Other: (please specify) _____

3. What is your highest level of formal education?

☐ Primary

☐ Secondary

☐ High school

☐ Vocational / technical training

☐ University (Bachelor, Master, Doctor)

Other: (please specify) _____

4. The place you are living in is a:

☐ City

☐ Town

☐ Village

Other: (please specify) _____

5. What is your occupation? _____

6. The first visit is the first time you meet a doctor for a new concern, and a follow-up visit is when you meet a doctor for an existing concern. This is a _____ visit.

☐ first

☐ follow-up

Thank you for taking the time to complete this questionnaire!

Appendix N: Questionnaire for patients (Vietnamese version)

BẢN KHẢO SÁT BỆNH NHÂN

Mã số:.......
(Xin để trống phần này)

Tên dự án: **Giao tiếp giữa bác sĩ và bệnh nhân Việt Nam**

Xin đánh dấu ☑ vào ô phù hợp

1. Giới tính của Quý vị:

☐ Nữ   ☐ Nam

☐ Không tiết lộ

2. Quý vị nằm trong nhóm tuổi nào?

☐ 20 – 25   ☐ 56 – 60

☐ 26 – 30   ☐ 61 – 65

☐ 31 – 35   ☐ 66 – 70

☐ 36 – 40   ☐ 71 – 75

☐ 41 – 45   ☐ 76 – 80

☐ 46 – 50   ☐ 81 – 85

☐ 51 – 55   ☐ 86 – 90

Khác: (xin nêu rõ) _____

3. Trình độ học vấn cao nhất của Quý vị?

☐ Tiểu học

☐ Trung học cơ sở

☐ Trung học phổ thông

☐ Đào tạo nghề hoặc kỹ thuật

☐ Đại học (Cử nhân, thạc sĩ, tiến sĩ)

Khác: (xin nêu rõ) _____

4. Nơi Quý vị đang sống là:

☐ Thủ đô hoặc thành phố

☐ Thị trấn

☐ Làng quê

Khác: (xin nêu rõ) _____

5. Nghề nghiệp của Quý vị? _____

6. Ca khám bệnh lần đầu là lần đầu tiên Quý vị được bác sĩ khám về căn bệnh mới (Quý vị có thể được bác sĩ này khám trước đây nhưng về bệnh khác), và ca tái khám là khi Quý vị đến theo dõi bệnh đã được khám trước đây.

Hôm nay Quý vị đến để:

☐ khám lần đầu

☐ tái khám

Cảm ơn quý vị đã dành thời gian hoàn thành bản khảo sát này!