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Getting to ‘no’: Three ways to jointly accomplish an answer to questions in a questionnaire in doctor–patient interaction

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Abstract

This paper aims to describe the interactional processes through which a medical professional and a patient collaboratively accomplish filling out answers to a questionnaire. Empirical analysis of three different sequences from a video-recorded doctor–patient interaction in which questions of a questionnaire were answered with a ‘no’, reveals three different ways (or methods) in which doctor and patient accomplish this jointly. Applying ethnomethodological conversation analysis (EMCA) as our methodological framework, we conclude that the three interactional practices are fitted in relation to the constraints of the interview that is itself methodically aligned to the practices and organizational structures of the institution, a Danish hospital. Furthermore, we make the case that questionnaires are designed as idealizations of question-answer sequences, and as such do not operate at the same level of detail as the actual question-answer situation. Details that are crucial for the objective of the questionnaire (in this case providing information to a third party) may not be included in the recorded answer. Thus, we argue that in order to understand the informational value of recorded answers in questionnaires, we need to diagnose the interaction in which they were produced, i.e. to critically examine it.
**Keywords:** doctor–patient interaction; ethnomethodological conversation analysis; questionnaires; question-answer sequences

1. **Introduction**

In this paper we focus on the interactional process that leads up to recording answers in a questionnaire in an interaction between a doctor and a patient. Patients’ answers are often essential in determining treatment, and an analysis of how they may come about can contribute to the development of best practices and policies. As this paper will show, knowledge about interactional processes gives the clinician a better chance of understanding patients’ answers. Moreover, knowledge of this kind is central when individuals’ answers are supposed to be used for individual treatment.

To this end, we analyze three sequences in which an ear, nose and throat specialist (ENT doctor) asks a question from a questionnaire which the patient answers. We show how these are not straightforward question-answer sequences, but rather collaborative accomplishments in social interaction. In fact, these questions and answers are both shaped by and shape a specific interactional context for the task at hand: to ensure that information is obtained and recorded for safety reasons before an imminent Magnetic Resonance Imaging (MRI) scan. Additionally, we show how the details of asking and answering in local interaction are critical in order to accomplish the answer that is eventually stated in the questionnaire and, similarly, at a later stage and by a third party, to fully understand the recorded answer. Ultimately, we suggest that such details may be crucial for ensuring the safety that was the original objective of the questionnaire.

We also show that both social, interactional and institutional competence are involved in filling out a standardized questionnaire. We argue that further analytic awareness is needed
in the healthcare sector at large regarding (1) how the details of talk constitute what is *typified* as a specific answer to a standardized question (Rasmussen 2017) and (2) how questions in standardized surveys are designed to leave out these details. These two conditions may in some cases be counterproductive. We will show one such case amongst others in this paper.

First, we introduce EMCA as a methodological approach, followed by a literature review focusing on questionnaires as an interactional accomplishment. We then present a brief outline of the data corpus and a description of the data segments analyzed. The analysis is divided into three parts, each focusing on an ENT doctor and a patient’s mutual accomplishment of the answer ‘no’ to a question from a questionnaire. Finally, the three different methods used to accomplish the ‘no’ are summarized and discussed in terms of in what sense questionnaires as an information seeking-strategy can be a valid and transparent strategy for obtaining information in healthcare.

2. **Methodology**

Ethnomethodological conversation analysis (EMCA) is a methodological framework for analyzing the practical accomplishment of mundane activities that people are engaged in (Maynard and Clayman 1991). EMCA holds that meaning is accomplished intersubjectively by the participants. This is achieved by taking turns, i.e. participants speak one after one another. The turn-taking system enables participants to monitor how co-participants understand and pick up on every turn-at-talk (Schegloff 2007). Hence, sequential organization of talk-in-interaction is a key feature and resource for participants to accomplish social action and meaning.

EMCA has been widely applied to the study of social interaction within institutional settings (Drew and Heritage 1992) including healthcare settings (Heritage and Maynard 2006). As noted by Pilnick *et al.* (2010: 2): ‘Of particular significance for medical sociology
is CA’s ability to reveal and unpack the fundamentally collaborative and contingent nature of medical encounters’.

3. Literature review

EMCA studies have revealed the systematic structure of central and specific practices within the medical encounter, such as patients providing accounts for having come to seek medical attention (Heritage and Robinson 2006) and doctors prefacing questions with ‘and’ (Heritage and Sorjonen 1994). Likewise, medical encounters in specialized settings such as audiology clinics (Brouwer 2012; Heinemann and Matthews 2015), physiotherapy (Martin 2009) and speech-language pathology (Isaksen and Brouwer 2015; Rasmussen 2013; Wilkinson 2015) or involving specific populations such as children (Clemente 2010) have also been investigated. Furthermore, interaction between healthcare professionals, technology in healthcare practice interactions and patient–patient communication has been researched (Andersen 2015). However, to our knowledge, the way in which doctors and patients interactively accomplish a seemingly widespread activity of completing a questionnaire providing information for third parties has not been investigated in detail.

Written questionnaires are used extensively in surveys to collect measurements from a sample to estimate characteristics of a population. In standardized survey interviews, which are often conducted over the phone, a three-part action sequence – consisting of (a) a question read aloud by the interviewer, (b) an answer by the respondent and (b) acceptance of the answer by the interviewer – is considered the prototypical sequence (Houtkoop-Steenstra 2000). Upon this interactional sequence, the interviewer typically types in an answer. Hence, when carrying out survey interviews, participants take on situation-specific identities as interviewer and respondent.
Further, as argued by Houtkoop-Steenstra (2000), interviewers ask questions, not on behalf of themselves, but on behalf of somebody else, and can in terms of Goffman’s (1981) concept of ‘footing’ be seen as ‘animators’, i.e. the ones vocalizing an action. The designer of the questionnaire is the ‘author’, the one who composed the utterance, as well as the ‘principal’, the one whose position, stands or beliefs are expressed in the utterance. However, although it is generally found that interviewers are nothing but ‘animators’ in standardized survey interviews, Houtkoop-Steenstra (2000) shows that the interviewer may take on different production roles when confronted with clarifying questions or answers that do not match the answer options on the questionnaire format. For example, when clarifying, interviewers may speak for themselves or speak for the investigator (i.e. the person who has formulated the written questions). When dealing with unformatted answers, interviewers may speak for the respondents by verifying a reformulation of the answer. To this we add the circumstance that the recipient of the achieved answers is not necessarily the ‘principal’. In the case of the use of standardized questionnaires in a hospital, the recipient is an unknown staff member, who did not formulate the questions. This is crucial to understanding the nature of the questionnaire, which leaves room for only yes/no answers that are supposed to be not only understandable but also non-misunderstandable, leaving no room for, in this case, the retrieving staff member’s ’subjective’ interpretations, and which can thus be retrieved by anybody in the institution without the risk of causing ‘errors’ that are based on ‘communicative misunderstandings’.

4. Data

Data for this paper stems from a large corpus consisting of about 41 hours of video-recorded interactions collected in Denmark between clinicians (ENT doctors, audiologists and speech and language pathologists) and patients with difficulties related to hearing, language and
communication. The encounter was recorded after obtaining written consent from the participants and was chosen as an exemplary case of the extensive use of questionnaires in healthcare, which is often presented as information and seldomly investigated and problematized in terms of its interactional accomplishment. No further ethical clearance was required according to Danish legislation. The recording was transcribed and analyzed in detail by the authors. Transcript notations can be found in the appendix. Rigor was established through joint data sessions and discussions with fellow researchers.

In this paper we investigate three examples in which in ENT doctor and a patient collaboratively accomplish filling out a questionnaire. Here, the ENT doctor has a questionnaire on his computer screen. In principle, his task consists of reading out the questions from the questionnaire on the screen and typing in the reply the patient provides in the format that is required. We focus on how the ENT doctor and the patient accomplish the task of filling out a written questionnaire and, in doing so, how they manage situation-specific roles of being interviewer and respondent. Additionally, we focus on how the interactional processes conform to the constraints of the questionnaire, i.e. the possibilities for answering ‘yes’ or ‘no’. As we will show, the seemingly similar questions ‘do you suffer from claustrophobia?’ and ‘do you have a pacemaker?’ are both to be answered with a ‘yes’ or a ‘no’ and both are central to the decision as to whether to carry out an MRI scan for which the patient in our case is being referred. However, they differ in that the first one may elicit wordier answers than the latter.

5. Analysis

5.1. ‘No’ – the interactional accomplishment of an answer

Answers to questions in questionnaires that are captured in writing are seemingly treated as unproblematic: Healthcare professionals encounter them as clear and unambiguous. Hence,
for the most part they will be taken for granted and made use of in subsequent examinations and treatment. Excerpt A1 exemplifies how such a seemingly unproblematic answer to a question may come about, which is in line with how a prototypical action sequence looks like in standardized interviews. The ENT doctor poses the question, and the patient delivers the answer. Subsequently, the ENT doctor accepts the answer and enters it into an electronic questionnaire. As already mentioned, the questionnaire serves to provide the unit responsible for MR scans with information about the patient. Hence, as in standardized interviews, the doctor now vocalizes the written questions and takes on the situation-specific role as interviewer and the production role as animator.

**Excerpt A1**

1. **ENT:** lider | du af det der hedder (.)
   
   klau(.)stro(.)fo(.)bi,

   *do you suffer from so called claustrophobia*

   gaze P→ K E | P→E

2. **Ps** (0.5)

3. **PAT:** ah:ej (. ) [det gør jeg ik]

   *no I do not*

   gaze P→E

   vis [(PAT swings to the left in the chair)]

In line 1 the ENT doctor asks a straightforward question ‘*do you suffer from so called claustrophobia*’. The question is a polar question (Stivers 2010). The form of such a question restricts the type of answers that the patient can relevantly give to it: A typical answer to it is
‘yes’ or ‘no’ (Raymond 2003). The answer, accordingly, in line 3 is ‘no I do not’, and that answer, the ‘no’, is entered into the electronic questionnaire. The questionnaires are of course designed to achieve exactly that. However, recorded answers, like the ‘no’, do not reflect the interactive process that generates them and thus do not depict the understanding of what kind of ‘no’ the answer is. As we will argue in the following, the ‘no’ that was written down is not a straightforward ‘no’ in the interaction that it is a product of, and the information that is handed over to the MRI unit is thus missing valuable knowledge about the patient.

The answer and the understanding of it emerge out of the details of contributions and processes in the interaction; it is produced in a very specific way, as shown in Excerpt A2.

**Excerpt A2**

3 PAT:  ah:ej(.)[det gör je ik]

gloss no I do not

gaze P↔E

vis [((PAT swings to the left

in the chair))]

4 PAT:  [(jeg ka)]

(I can)

gaze P↔E

vis [((PAT swings to the right

in the chair))]

5 Ps  (.)

6 PAT  [*hh je går ik | alene [i he:h*]

I will not go alone in heh

gaze P↔E  | P↑ ←E

vis [((PAT swings to the left
PAT: in an elevator

7  PAT: i en elevat | or

in an elevator

gaze P ↘ E | P→E

vis ((PAT continues to swing
to the left in the chair))

The ‘no’ in line 3 does not entirely correspond to an English ‘no’. A straightforward ‘no’ in Danish is ‘nej’. The way the negation ('ah:ej') is produced, however, is understandable as indicating a ‘no’ with modification, hence it projects elaboration. In fact, the elaboration is produced immediately after the modified no, as the patient states that she will not enter an elevator by herself. She states this while swinging in the chair which might project that more is coming. The modified and elaborated answer indicates that the patient, although she does not consider herself to actually ‘suffer from claustrophobia’, has issues with confined spaces.

Further, by voicing this to the doctor, she indicates an understanding that the doctor might take on the role as someone with competences to either acknowledge the adequacy of the first answer given for the current purposes in spite of the modification following it, or suggest that another answer (i.e. ‘yes’) should be entered instead, as the questionnaire is not designed to incorporate modified answers. This then implicates for the ENT doctor to decide whether to note down a ‘yes’ or a ‘no’, and the patient seems to put the doctor in a position in which the interviewer role as an animator does not suffice. In Excerpt A3 The ENT doctor recognizes the patient’s answer (‘no’) and indicates at the same time troubles in handling it.
Excerpt A3

8 ENT: nej:
   No
  gaze P↔E

By not only saying ‘no’, but also by prolonging the consonant, the ENT doctor indicates that he has problems understanding what kind of answer has been given. Furthermore, he gives back the turn-at-talk (Schegloff 2007) to the patient without having pushed the interactional business forward, e.g. without changing the production role as animator of written questions by making judgments about the adequacy of the answer given with modification. In Excerpt A4 the interactional and normative consequence of such conduct is that the co-participant, here the patient, continues her talk, elaborating her previous answer.

Excerpt A4

9 PAT: [men jeg har altså klaret=]  
   But I actually managed it
  gaze P↔E
  vis [(PAT turns head and face towards ENT)]

10 ENT: =>°nå det har du°<=  
   okay you did
  gaze P↔E

11 PAT: [je har] klaret  
   I did make
  gaze P↔E  P→ K
  vis [((ENT nods twice))]
The patient produces a turn, which from the start is formed as an opposition to her previous statement (‘but’, line 9), i.e. it indicates that the previous assertion of not going into an elevator by herself will be put further in perspective. Before her turn is finished, however, the ENT doctor acknowledges the perspectivation (‘okay you did’, line 10). Rather than confirming this, the patient restarts her assertion and finishes by stressing that she did make it – on two specific prior occasions (lines 11–12). The result is thus the following: the patient has responded with a modified ‘no’ and twice a modification of that ‘no’, now stressing the capability of going through a scanning. The patient exhibits an understanding of what the question is for and makes it relevant that this capability is restricted to a specific limited number of times where the capability is asked for. Moreover, doing so in the context of having indicated suffering from claustrophobia is understandable as having to make a lot of effort coping with MRI scanning.

As mentioned, the elaborations do not fit the questionnaire answer formats; however, by elaborating, the patient is inviting the ENT doctor to deal with them interactionally. The doctor complies by using techniques of repeating and acknowledging receipt, thus giving the turn back to the patient without assessing the answer or the elaborations in terms of their possible impact on the adequacy of the answer given. Hence, he does not indicate whether the elaborations in his (professional or personal) opinion would qualify as reasons for changing the initial response ‘no’, and thereby he avoids taking the production role as principal.

In Excerpt A5, right upon completion of the patient’s turn ‘I did make it’ (lines 11–12), the ENT doctor nods and shifts gaze direction from the patient to the monitor. This
action could be understood as a closure of the topic. The patient, however, has not finished her turn yet and continues as she states that she endured a scan on two specific occasions. The ENT doctor orients to this elaboration minimally.

**Excerpt A5**

<table>
<thead>
<tr>
<th>Line</th>
<th>PAT:</th>
<th>Engagement</th>
<th>ENT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>[je har]</td>
<td>klaret</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>I did make</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>gaze</td>
<td>P↔E</td>
<td>P→ K.E</td>
</tr>
<tr>
<td></td>
<td>vis</td>
<td>[ENT nods twice]</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>det derover de to gange</td>
<td><em>it over there on these two occasions</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>gaze</td>
<td>P→ K.E</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>[ja]</td>
<td><em>yeah</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>gaze</td>
<td>→ K.E</td>
<td></td>
</tr>
</tbody>
</table>

The ENT doctor acknowledges the patient’s statement with ‘yeah’, line 13, as he continues gazing at the monitor. With his continued gazing action, the ENT doctor thus pursues a closure of the topic again. Thus, he indicates that the relevant answer has already been delivered and that the details of the talk, including ‘I did make it’, can be boiled down to a ‘no’ as an answer to the question.

This is, however, not the end of the story. The patient continues her talk concerning claustrophobia in Excerpt A6.

**Excerpt A6**
In line 14, the patient elaborates her previous turn (lines 11–12), making explicit that she knows what it is like, after having stated twice that she made it on two other occasions. This can then be heard as an indication of how she deals with claustrophobia: knowing what is going to happen is knowing the details which one may focus on in order to prevent claustrophobic attacks. Again, the ENT doctor does not deal with such an understanding in his subsequent turn. Instead, he pursues closure of the topic by continuing gazing at the monitor, acknowledging that the patient knows what it is like by saying ‘yeah I thought so’ (line 15) and by filling in the answer in the form (line 16). Still, the patient continues in Excerpt A7.
This time, the patient explicitly addresses being 'uncomfortable' (lines 18-19). Again, the ENT doctor does not respond and hence treats it as no longer relevant. Simultaneously, he continues gazing at the monitor. As the ENT doctor does not respond to the patient’s assessment of scanning being uncomfortable, the turn is delivered back to the patient. She chooses to continue her talk on the topic by modifying her statement. The modification is initiated by ‘but eh’ (line 19), but not ended immediately, which is due to a delayed acknowledgment by the ENT doctor while he keeps on gazing at the monitor (line 20). This gazing thus indicates that the patient’s assessment and the third indication (the first was in lines 6–7, the second in lines 9–12) of suffering from claustrophobia is not relevant for the business at hand, which is filling in the form.

In Excerpt A8 the patient seems to go along with this in her subsequent action as she again modifies her statement indicating that she suffers from claustrophobia.

Excerpt A8

21 PAT: [det er ik noget der varer
så længe jo.

it does not last

that long of course

gaze P→ ▲ E

22 ENT: [nej]

no

gaze P→ ▲ E

vis [((ENT nods))]

The patient thus constructs this statement as a closing action by way of a falling intonation contour indicating that there is no more to come. The ENT doctor acknowledges the patient’s closing action as he nods, while continuing gazing at the monitor. He then proceeds by asking the next question in the questionnaire (not shown in the transcript).

The answer to the question in the questionnaire of whether the patient suffers from claustrophobia is captured as a ‘no’. This recorded answer, however, leaves no trace of the social interactional processes that lead to it. As the detailed sequential analysis of the interaction between the ENT doctor and patient shows, this is not unproblematic. Every process of this kind is crucial for understanding the answer. Some questions seem to call for a need to explicitly look for the details of the talk: the concept of ‘claustrophobia’ is not straightforward, it seems. At which point does an uncomfortable feeling of being in a small room count as claustrophobic? Wordy descriptions to articulate experiences relating to claustrophobia may thus be relevant. The reduction of the details of the talk with the purpose of typing it as e.g. a ‘no’ is, however, as we have seen, not just a reflection of the patient’s understanding and her description. Instead it emerges out of the patient’s and the professional’s contributions. Through such interactional processes the answer (here ‘no’) to the question (here, ‘do you suffer from claustrophobia’) then becomes a no. The answer
becomes a ‘no’ as a product of the interactive work accomplished by both participants – the patient and the ENT doctor. In the case at hand the answer became a ‘no’ due to the ENT doctor’s treatment of some of the patient’s actions and responses as relevant and others as not relevant and the patient’s orientation to that treatment of her contributions to accomplishing their common task of filling in the questionnaire.

The fine-grained process of working out between the ENT doctor (relying on his professional knowledge) and the patient (relying on her previous experiences) whether specific measures could or should be taken when administering an MRI scan in relation to subjective understandings and experiences of claustrophobia is not reflected in the ‘no’ that appears on the questionnaire. This is the result of institutional information-collecting processes that are made relevant through the organizational structures of the hospital. The information is handed over to another ward and is to be retrieved by an unknown staff member in the ward. Both the ENT doctor and the patient are subject to these constraints.

5.2. Checking for understanding

Excerpts B1–B3 shows a sequence in which a different method is used to arrive at entering an answer into the questionnaire. The answer is still accomplished jointly as a product of an interactional sequencing process. In this case, however, the ENT doctor enters the patient’s answer after ensuring that the patient understands the question posed (Excerpts B2 and B3), i.e. not immediately after the no-response provided by the patient in line 36 of Excerpt B1.

Excerpt B1

30 ENT: [så spørger jeg dig,  
then I ask you

gaze P→ KesE
vis 

31 ENT: har du nogensinde haft,

have you ever had

32 Ps [(1.0)]

33 ENT: eller har du en.

or do you have one

34 ENT: det der hedder pacemaker
gloss what is called a pacemaker

35 Ps (.)

36 PAT: ngej.

No

vis
The ENT doctor initiates the sequence while gazing at the computer screen in front of him as he announces his next action: ‘Then I ask you’ (line 30). By using this formulation, he stresses his role as animator of the questions in the questionnaire.

The question (lines 31–34) is divided into three parts using intonation, pauses and gesture. In this way, the ENT doctor shows that, to answer his question, a consideration of both the past and the present and knowing what a ‘pacemaker’ is are relevant. By stressing certain elements of the question, and by possibly reformulating the question from the questionnaire to also include an element of knowing a term, the ENT doctor takes responsibility for composing the question and for securing that the question and all of its elements have been considered and understood in order to secure a valid response. In fact, the way ‘pacemaker’ is introduced by the ENT doctor, as ‘what is called a pacemaker’ (line 34), makes it relevant for the patient to voice it if she does not know what a pacemaker is. This does not happen. Instead the patient responds ‘no’ in line 36, thereby providing a type-conforming (Raymond 2003) response to the ENT doctor’s question.

The sequence which entails the first two of the three actions comprising a three-part action sequence in standardized interviews, in principle, could be closed at this point – the ENT doctor has obtained a type-conforming answer to acknowledge and type in the questionnaire. In line 37 of Excerpt B2 however, the ENT doctor poses a follow-up question to the patient: ‘do you know what we are talking about’. Thus, the sequence is marked as not yet finished, as he orients to the part of his turn, which the patient did not deal with in her answer.

**Excerpt B2**

37 ENT: [ved du] godt hvad vi snakker

om=
do you know what we are talking

About

gaze P↔E

vis [((ENT opens his right hand and
puts it back on the left forearm))]

38 PAT: =hj[a]

Yes

gaze P↔E

With this request for information (line 37) the patient is invited to deal explicitly with the supposition that lies in the original question: whether she knows what a pacemaker is or not. In other words, the ENT doctor communicates that the patient’s response in line 36 (Excerpt B1) only counts as a valid response to the question he has posed under specific circumstances. This is different from the positioning of interviewers in standardized interviews who read scripted questions and declare themselves not to be responsible for the questions (Houtkoop-Steenstra 2000). The patient immediately responds ‘yes’, thereby acknowledging that she knows. As shown in Excerpt B3, however, the ENT doctor is not ready to accept the answer provided by the patient, as he once again poses a question about the patient’s knowledge about what a pacemaker is.

Excerpt B3

39 ENT: [d]u ved godt [hvad det er

En pacemaker
gloss you know what it is a pacemaker
gaze P↔E

40 PAT: [Ja. Det ved jeg godt ja
yes, I do know yes

gaze P↔E

41 PAT: j[a] ja

yes yes

gaze P↔E

42 ENT: ja]

yes

gaze P↔E

43 PAT: [det ved jeg godt]

I know

gaze P→↖ E

vis [((ENT turns torso to the right
now facing computer screen and moves
right hand to computer mouse))]

44 ENT [ja]

Yes

gaze P→↖ E

vis [((moves right hand on computer
mouse slightly))]

45 PAT: Hja

Yes

gaze P→↖ E

46 Ps (2.1)

47 aud ((clicking sound from
computer mouse))
The ENT doctor provides a reformulation of his request for information (line 37), and thereby also provides his understanding of what it is the patient has implied with her ‘yes’: ‘you know what it is a pacemaker’ (line 39), and makes it relevant again that the patient deals with his question and in particular the meaning of the word ‘pacemaker’, which has now been reintroduced. Thus, the ENT doctor significantly and repeatedly extends the question-answer-acknowledgement-sequence through which the interview is conducted.

The patient starts responding to the ENT doctor’s request even before the ENT doctor has finished his turn. The patient initiates her response with ‘yes’ (line 40) followed by a formulation very similar to the wording used by the ENT doctor in his request: ‘I know’ (line 40). The patient then says ‘yes yes’ (lines 40–41) and repeats a previous statement, ‘I know’ (line 43), which partly occurs with an acknowledgement by the ENT doctor, ‘yes’ (line 42), and is also followed by an acknowledgement, ‘yes’, line 44. By responding with ‘yes’ the ENT doctor finally shows that he has heard and has accepted the patient’s response – that is, he acknowledges that she knows what a pacemaker is, and thus, the answer to the original question can be taken as the ‘right answer’. Note, however, that the patient has only claimed that she knows what a pacemaker is, and she has not demonstrated it by e.g. giving an explanation – which was possibly the type of assurance the ENT doctor was after (Houtkoop-Steenstra 1986). The ENT doctor then turns his attention to the computer; he turns his body, puts his right hand on the mouse and gazes at the computer screen. In this way, he shows that he is ready to type in the patient’s response to the question.

The ENT doctor’s pursuit of a demonstration of knowledge by the patient is an example of how professional and institutional knowledge systems come into play in a task of filling out a questionnaire in this setting. While the patient seems to orient to the answer ‘yes’ as sufficient for the current purpose, the ENT doctor takes responsibility for composing the question asked and for checking understanding, which is not a practice described to occur
systematically in standardized interview situations. On the contrary, in these situations, respondents are often the ones to request clarification and explanation of questions by interviewers (Houtkoop-Steenstra 2000). It should also be noted that the ENT doctor’s concern with understanding only applies to the patient’s understanding of the question, not to his understanding of the answer. This, of course, can be related to the constraints of the standardized interview that, as mentioned, is designed to leave out details of how to understand answers.

5.3. Establishing mutual agreement of an answer

We have so far seen two different instances of arriving at the answer ‘no’ to be recorded in the questionnaire, in which either the ENT doctor or the patient does additional interactional work to arrive at mutual understanding. In Excerpt C, which is also part of the activity of filling out a questionnaire, we see both participants orienting to achieving agreement on which answer should be entered, although both participants orient to the answer as self-evident.

Excerpt C1

50 ENT: [gravid=

*pregnant*

\hspace{10mm} gaze P→ E

\hspace{10mm} vis [((ENT has his right hand on the mouse of the computer)]

51 aud [((=clicking sound from mouse)]

\hspace{10mm} gaze P→ E

\hspace{10mm} vis [((ENT has his right hand]
This sequence initiates with the ENT doctor saying ‘pregnant’ (line 50). In the context of filling out a questionnaire, this is understandable as a question inquiring about whether the patient, who is a middle-aged woman, is pregnant or not. Hence, it is understandable as the ENT doctor’s reformulation of a scripted question formatted in a way that signals his understanding of the question as redundant. After having posed the question, the ENT doctor moves the mouse and it makes a hearable clicking sound. This might be understandable to the patient as if the ENT doctor has anticipated her response and does not wait for her to voice it, before entering it. The ENT doctor then moves his gaze and his right hand to the keyboard.
The patient’s mouth opens a bit, but she does not voice anything. The ENT doctor announces ‘we will write zero there’ (line 55). By answering on behalf of the patient, the ENT doctor takes the production role as principal; however, the utterance is formulated as if the accomplishment of answering is being made jointly, and it implies that it is done in agreement between the participants. The patient gazes at the ENT doctor’s hand, which is now placed at the keyboard. Thus, she orients to monitoring the ENT doctor’s accomplishment of answering, that is, typing in the answer. The patient states a loud and clear ‘yes!’ (line 56), after which there is a hearable clicking sound from the keyboard. This can be understood as the ENT doctor having now typed in the answer on the computer. The ENT doctor gazes at the patient while smiling, and the patient laughs. In this sequence the patient orients to the question, ‘pregnant’ (line 50), as not necessarily requiring her to voice a response. She orients to the answer as likely to be self-evident. The ENT doctor orients to this as well: he poses the question in a minimal way, gazes at the computer and thus seems occupied with typing in the answer and announces what answer he will type. On the other hand, he refrains from typing in the answer until the patient has voiced an acceptance of his announcement of the answer he is going to record. In this way, the activity is accomplished as one in which both participants should accept which answer should be typed in. This example shows that even in cases in which an answer is presented as self-evident, both participants work towards mutual agreement on which answer is to be typed.

6. **Discussion and conclusion**

The analyses of three different sequences in which a question of a questionnaire was answered with a ‘no’ have revealed that getting to that ‘no’ can take place in quite different ways. We have shown how the three methods fit the constraints and purposes of the interview in three distinctive ways: namely, by treating modifications of answers as irrelevant; by
ensuring validity by checking that questions are understood; and by accomplishing mutual understanding that some questions, and therefore the answers to them, are redundant, albeit required to accomplish the task.

The paper contributes to the growing body of interactional research focusing on the processes through which patients deliver answers to healthcare professionals’ questions (Heritage 2010). This research has generated knowledge about the kind of interactional processes which are likely to lead to the prescription of medicine and which are not (Heritage et al. 2010). It also contributes to research in the use of standardized surveys (Houtkoop-Steenstra 2000; Maynard et al. 2002) and other standardized methods in the health care sector (Brouwer and Day 2012; Rasmussen 2016).

In the healthcare sector at large, communication is overwhelmingly treated as information. Efforts are made to reduce communicative misunderstandings which may have risky consequences. However, we suggest that methods such as standardized questionnaires which aim at obtaining transparent information may provide such answers, but that they provide opportunities for ‘errors’ to occur during the production of the answers. We propose that the human sciences still have work to do to make health care science aware of the need for diagnosing communication to understand what it conveys (Rasmussen 2016).

It may appear to the reader that we are problematizing conduct which was done in a professional and unproblematic way. The ‘no’s, although they have been produced in entirely different interactional contexts, are the answers that should have been entered. In other words, we do not contest that the product of these sequences are valid answers. Similarly, we do not make the point that every sequential context is different and thus that the validity of answers in a questionnaire can only be warranted by looking at the contexts in which those answers have been produced. We rather point to the fact that the work that was done in our case study to get at these valid answers is a joint accomplishment of the ENT doctor and the
patient. These joint accomplishments for the three instances described are different, but they are also recognizable.

Getting to a valid ‘no’ for healthcare professionals means, in some cases, to suggest an answer and just a small opportunity for confirmation; in others to repeatedly investigate the presupposed knowledge of a pre-fabricated question in a questionnaire; or in yet other cases to give enough time for patients to modify their answers. We showed how the ENT doctor and the patient in doing so balance and orient to both situation-specific roles of interviewer and respondent as well as institutional and social roles and knowledge related to the purpose of the specific interview.

Appendix

Transcript notations generally follow Jeffersonian transcription conventions as described by Hepburn and Bolden (2013). The symbols we use are listed below.

Line notations:
ENT: utterances produced by the ENT doctor
PAT: utterances produced by the patient
gloss: English gloss of the utterance
vis: Comments on or descriptions of nonverbal gestures
aud: Sounds not produced by speech
gaze: Gaze direction of each participant in each turn is indicated under each turn and English gloss. The patient’s physical position is marked with P and the ENT doctor’s position with E relative to each other, and the errors indicate gaze direction (see Rossano 2013). Shift in gaze is indicated with │ and the placement
of the shift is also marked with | in the turn which the shift of gaze co-occurs with

Ps  Pauses between speech

Symbols used to mark temporal and sequential relationships between actions, speech delivery and intonation:

[]  Overlap between talk OR co-occurring talk and non-verbal gestures and/or sounds

(( ))  In order to distinguish speech from descriptions of actions, descriptions are placed within double parenthesis

(0.2)  Inter- and mid-turn silences represented in tenths of a second

(.)  A dot in parentheses indicates a pause less than 2/10 of a second

↑  The syllable following the arrow is sharp rise, a shift or resetting of the pitch register

=  The equal sign links two adjacent utterances when there is no perceptible interval between them OR the equal sign links different parts of a single speaker’s continuous flow of speech that has been carried over to another line to accommodate an intervening interruptio

?  Rising intonation

:word:  Colons represent lengthened vowels and consonants. The number of colons shows the relative stretch of sound

.  Indicates falling intonation contour

,  Indicates raising to mid intonation contour

*word*  indicates that the speech is produced with a ‘smiling voice’

(word)  indicates doubt about the speech which has been transcribed
indicates that the speech produced has not been identified

> Faster talk

< Slower talk

**Author statements**

The authors confirm that all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story. The authors declare they have no conflicts of interest.

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