

WHAT COUNTS AS ILLNESS? ANAMNESIS AS A COLLABORATIVE ACTIVITY

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Drawing on a corpus of 35 videorecordings of cancer consultations collected in a medium-size public hospital in Italy, our analyses show how anamnesis, rather than being an automatic sequence of brief and polar (yes/no) questions addressed by the doctor to the patient, results as a challenging interpretative joint activity; in this activity, the doctor and the patient need to collaborate in order to build a shared sense of salience of what compels attention in the actual clinical situation. Results show the interplay of doctor's and patient's different knowledge systems and classification practices, involved in defining what an illness is. Anamnesis proves to be a suitable site for patient's socialization in medical encounters, and a highly collaborative activity due to the amount of interaction and negotiation between the doctor and the patient (higher than those in other stages of the visit).

Key words: Anamnesis; Oncology; Classification; Patient socialization; Patient education.

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Recently, the study of patient-doctor interactions in oncology settings has received considerable and increasingly wide attention (Ford, Fallowfield, & Lewis, 1996; Robinson, Hoover, Venetis, Kearney, & Street, 2013; Venetis, Magsamen-Conrad, Checton, & Greene, 2014). In the oncological “first time” visit, communication has been described as particularly complex and sensitive (Beach, 2012), for at least three reasons: 1) the need for the patient and the doctor to get to know each other (Gattellari, Voigt, Butow, & Tattersall, 2002); 2) the patients' psychologically and emotionally vulnerable state as they have learnt of their cancer diagnosis only shortly before the visit (Siminoff, Fetting, & Abeloff, 1989); 3) the amount of information the oncologist has to deliver to the patient and the relevance of the decisions that both the oncologist and the patient have to face (e.g., treatment choice, forthcoming exams, etc.).

Moreover, studies of these visits highlighted how doctors and patients might navigate the encounter with different knowledge and interests, adding to the complexity of the communicative event. In particular, studies have opposed the doctor's professional and biomedical agenda to patient's lay and psychosocial agenda (Mishler, 1984).

Similarly, Mol (2008) underlined that in medical encounters different types of logic are at play. In a rationalistic view, medicine is described as a stable corpus of knowledge and categories from which diagnostic decisions and therapeutic actions will “automatically” stem, following a rational choice logic. The doctor's task is to choose an option within a given and well-known decisional tree and knowledge domain (Falmagne, 2000; Han, Klein, & Arora, 2011; Kostopoulou, Russo, Keenan, Delaney, & Douiri, 2012).

The logic of care is, in contrast, unbounded, non-linear, and unpredictable (Mol, 2008). In this type of logic, the doctors are described as “navigators,” rather than rational decision makers. They engage onto interpretative paths, which help them “to determine the best action to take when knowledge depends on circumstances” (Montgomery, 2006, p. 5). In a similar manner, Toulmin (1996) argued that in medical practice there are not “typical” cases to be diagnosed, rather situations that resemble one another only partially. Thus, doctors should follow a situated rationality that enables them to deal with the complexity, uncertainty, and local specificities of their professional work.¹ The logic of care includes those actions, interactions, and practices that doctors and patients engage in together to face the illness (Mol, 2008). In this view, medical visits are situations within which many factors meet and clash, modifying each other at the same time: the technical and social aspects; the patient’s everyday life and organizational hospital context; scientific and common sense knowledge; temporal landscapes and perspectives; material artifacts and identities. During the visit, the participants attend a practical and situated logic, in which the boundaries between professional and lay system of knowledge and classification vanish and become less rigid.

The International Classification of Disease (ICD) is the key classification system of medicine around the world. This system, which is continuously modified and updated, is taken as the main point of reference by National Health Systems, pharmaceutical industries, medical formularies, health insurance companies and health policy departments. In spite of being an internationally acknowledged classification system, the ICD is not free from ambivalence and ambiguities. For example, it only records and “classifies” the diseases with a statistically significant diffusion (Bowker & Star, 1999). Moreover, there are different positions on how the diseases should be classified, which also take into account data from developing countries (Setel et al., 2004). For many years, all mental diseases have been classified in an autonomous system (Diagnostic Statistic Manual of Mental Disorders, DSM), which was developed due to theoretical and ethical divergences with the ICD. In turn, the DSM is also continuously changing: versions of it are increasingly renewed and many of its classifications are debated and discussed (e.g., “Can homosexuality be considered a psychiatric matter?” “Should narcissism still be identified as a personality disorder?”).

Furthermore, the classification systems that we use in our everyday life are situated, ambiguous, partial, and always editable. Moreover, their categories’ borders are always blurred. They are pervasive, widespread material objects mediating every practice of our lives. They incorporate certain relevancies (i.e., decisions about what should or should not be visible) as well as the different “voices” that have collaborated in their making and development (Bowker & Star, 1999). Nevertheless (or perhaps because of this), these systems are necessary for transforming and fixing the continuous flow of different events in distinct categories. These latter allow us to undertake actions in the world as well as to perform specific professional duties and tasks.

The partiality and ambiguity of the classification systems connote them as “boundary objects” (Bowker & Star, 1999), namely, objects usable in many situated ways, connecting and putting in interaction many social actors and communities (e.g., the case of doctors and patients in a medical visit). Thus, what is at stake here is not an opposition between a formal, professional and “true” classification system on one hand, and an informal, naive and imprecise system, on the other. Rather, in both our everyday and professional lives we always use a hybridization of more or less formal classification systems.

Two scholars contributed first to go “beyond” hierarchical, static, and supposedly based on formal logic representations of such systems. Nelson (1973, 1988) highlighted the importance of the

spatial/temporal aspects of such classification systems, suggesting the well-known notion of “script”; Rosch (1977) suggested the notion of “prototype,” which takes into account the ephemeral nature of categories’ borders, always defined by attributes that slightly and partly overlap, in a way that also recall the idea of “family resemblances” originally proposed by Wittgenstein (1953).

Goodwin (1994) characterized the process of categorization as a practice of transforming events, phenomena, and objects into relevant and salient categories for accomplishing specific professional activities. Goodwin (1995, 1997) studied the practices that participants use to develop and shape those relevant events and objects, which become “the insignia of their profession” (Goodwin, 1994, p. 606). These studies, which were carried out in different professional contexts (the legal argumentation during a lawsuit, the novices’ socialization in a biochemical laboratory and on an archaeological site) have identified three phenomena through which categorization practices are interactively realized: 1) the production of coding schemes, by which objects relevant for the activity at hand are transformed into professional categories and objects of knowledge; 2) highlighting, which marks the events relevant for accomplishing one’s professional activity as perceptually salient; 3) the production and articulation of certain phenomena’s material representations (such as inscriptions, texts, drawings, maps as regards, for instance, spatial phenomena), which transform these representations into usable and relevant objects for local courses of action.

Goodwin (1997) showed how the expert, through the collective engagement of activities with the novice members, develops a framework of relevance, in which some actions and phenomenological characteristics are made perceptually salient and expected, whereas others fade into the background. Learning to categorize some aspects as relevant (and other as irrelevant) constitutes the “professional vision” of a particular community of practice. Such consistently partial and situated visions are at stake in every moment of our professional and everyday life.

THE ANAMNESIS PHASE IN ONCOLOGICAL “FIRST TIME” VISITS

In this paper, we focus on the analysis of the anamnesis phase in a corpus of 35 videorecordings (and transcripts) of “first time” visits conducted by an experienced oncologist in a medium-size public hospital in Italy. Anamnesis, which is widely studied in general practice visits (Stivers & Heritage, 2001), is used in oncology to identify the comorbidities that may be relevant for cancer treatment.

The patients usually come to the visit after a surgery or a radiological examination already with a diagnosis of cancer. The main objective is to decide the best cancer treatment to undertake. These visits are, thus, thick communicative and interactive events both for the doctors and the patients, given the amount and complexity of information they need to share about the disease and the relevance of the decisions they have to make, which affect the patient’s future quality of life. In such visits, anamnesis aims to build an as reliable as possible picture of the clinical history of the patient (including present and past illnesses, surgical interventions, current pharmacological treatments, etc.), beyond the recent cancer diagnosis. An accurate and rich reenactment of the patient’s clinical history allows the oncologist to tailor the treatment proposal to that particular patient, also taking into account the potential comorbidities and thus avoiding dangerous interactions with the cancer treatments (e.g., chemotherapy, radiotherapy, hormone thera-

py, and other therapies). The patients' contribution in this stage is pivotal, insofar as they are the only repository of the information regarding their health.

But what are the relevant illnesses and information that the patient needs to recall and report to the doctor? What can be dismissed instead as an irrelevant information here? What does the doctor consider as essential to apprehend, in order to select the most appropriate cancer treatment for that patient?

DATA CORPUS AND ANALYTIC PROCEDURES

Data Corpus

The corpus includes 35 videorecordings of first oncological visits in a day hospital of Oncology (engaging four doctors and six nurses) of a medium-size public hospital in Italy.² The target oncologist has more than 35 years of experience. Patients include 11 males and 24 females (20 having a diagnosis of breast cancer). Seventy-seven percent (i.e., 27 of the total 35) of patients came to the visit with an accompanying person (mostly family members). The visits, that last 26 minutes on average, were fully transcribed according to the Jeffersonian conventions (Jefferson, 2004).

Analytic Procedure

Prior work on the data has documented the structural organization of the first visits (Fatigante, Alby, Zucchermaglio, & Baruzzo, 2016). The first visit comprises six phases, that is, 1) Opening (greetings and small talk); 2) Anamnesis (personal data, medical history, current health status); 3) Cancer's diagnostic assessment (staging); 4) Treatment recommendations; 5) Outline of future actions (e.g., next appointments, exams); 6) Closing (greetings). The analysis of the anamnesis phase was accomplished at two different levels: a) on a quantitative level, we measured the average time dedicated by the participants to the realization of anamnesis over the visits and the amount of participation (measured as number of turns speaking per participant, on average) embodied, respectively by the oncologist, the patient, and the companion across the visits; b) on a qualitative level, analysis moved through the identification, across the corpus, of practices of problematic illness classification, that is, instances in which the classification rather than being a quite straightforward process required numerous exchanges between doctor and patient in order to achieve a common understanding. Each videorecorded visit was examined and coded independently by two of us and full agreement was reached on the identification of the problematic practices. Coders' inter-rater reliability for all the list of practices was acceptable (Scott's $\pi = .77$).

RESULTS

The length of anamnesis confirms its importance in the overall development of the first oncological visit. Within the overall data corpus, the anamnesis phase takes up on average 17.6% of the total length of the visit (about four and half minutes), with considerable variations, however, across visits (ranging from a maximum of 33.9% to a minimum of 2.1%).

The patient's participation in this phase is much higher than in all the other phases of the visit (on average, 43.7% of turns speaking vs. 46.8% of turns taken by the doctor). Also notable is the participation of the companions (ranging on average, from 13% to 38% of turns) who, as we will show in the next section, play quite a relevant role in the accurate realization of anamnesis. The almost (quantitatively) equal character of the participation shown by the doctor and the patient (including the patient's companion), as compared to other stages (where the doctor takes most of the turns speaking) marks this stage as a rather collaborative activity, specifically as regards illness classification practices.

Illness Classification as a Problematic Accomplishment

The opening of the anamnesis stage is signaled by a characteristic/recurrent question by the doctor, repeated with minimal variations across the different cases: "Do you have any particular illnesses besides this one?" This question solicits the patient to report information regarding the existence of other illnesses, in addition to the tumor recently diagnosed.

The adjective "particular" employed by the doctor tacitly incorporates a definition of some (specific) illnesses, which are important for the doctor to be aware of, in order to opt for a certain oncological treatment. Still, for the patient this characterization might not be clear at all: what does the adjective "particular" refer to? What illness has to be considered as a "relevant one" to be referred to the doctor?

In the following example, we observe how the patient responds to the doctor's initial question by a further request for specification, regarding the temporal characterization of the illnesses that can be of interest for the doctor: are they present (existing) illnesses or those that are distant in time?

Excerpt 1 — Visit 15 MC (Throughout the paper, the number and the acronym allow us to identify the visit from which the Excerpt is taken within the corpus. The meaning of the transcription symbols are reported in the Appendix).

Participants: Oncologist (ONC), Patient (PAT, male), Wife (WIFE)

- 1 ONC: fff fff gggg. e: piripì=piripì=piripì, (.)
 ((writing)) fff fff gggg. e: piripì=piripì=piripì, (.)
- 2 m: malattie particolari?
 m: any particular illnesses?
- 3 WIFE: ((she slightly waves her head))
- 4 (.)
- 5 PAT: adesso?
 at present?
- 6 ONC: a parte questa ovviamente.
 besides this one obviously.
- 7 PAT: e: pregresse? anche?
 a: previous ones too?
- 8 ONC: pregresse. cose importanti.
 previous ones. important things.
- 9 se ha avuto gli orecchioni, non fa niente, ma se c'ha avuto:
 if you had mumps, it doesn't matter, but if you had:

- 10 PAT: pregresse sì, so' stato operato a Bologna de: sarcoma di Ewing.
 I have had previous ones, I have been operated in Bologna for Ewing's sarcoma
- 11 ONC: ↑ah,
 ↑uh, ((writing))
- 12 PAT: tibia sinistra.
 left tibia.
- 13 ONC: hai fatto anche chemioterapia?
 have you done chemotherapy also?
- 14 PAT: ((nods))

The doctor responds to the patient's question by, on one hand, confirming that even illnesses that are distant in time (from which one has never "recovered") count as proper illnesses; on the other, by translating "particular" with "important." In order to bring this disambiguating activity — that allows the patient to respond — to completion, he provides an example of what can be meant by important illnesses: everything that happened in the past but however would not be as common, widespread and predictable as mumps (that almost everybody has had).

Despite this categorization being far from being precise and stable, it allows the patient to respond by referring an extremely severe oncological illness (Ewing's sarcoma). This is appropriately placed, then, in the category of the "previous" illnesses, a category that has just been collaboratively built in the interaction with the doctor. The importance of this unexpected information (being a rather rare illness in an adult, it is certainly important as regards future decisions to take in the course of the visit) is emphasized by the doctor, firstly, by a marker of surprise (Line 11) and then, by a question, aimed to better understand the medical treatment and chemotherapy that the patient underwent at the time.

We can observe that the initial question and the further specifications provided by the doctor are inherently ambiguous: the qualifiers and the exemplifications used (particular, important, mumps) do not precisely identify any category of illness, neither generally nor for the patient. Participants needed to engage in a subtle interactional work to make the actual cases fit in this "mobile" definition of illness. The patient here contributes in an extremely active way (he addresses the doctor with a clear-cut question about the temporal thresholds that are valid enough to categorize an illness as relevant), probably thanks to his previous experience as an oncological patient. In other cases, the interactive job necessary for the doctor and the patient/companion to share what has to be considered as a relevant illness is even more laborious than that.

In the following example, the doctor's question specifies that by "particular illnesses" one commonly means those for which the patient takes medicines. And notwithstanding the further solicitation by the doctor's incremental question "of any kind," the patient's answer is still "no."

Excerpt 2 — Visit 4 AMC

Participants: Oncologist (ONC), Patient (PAT, female), Daughter (D).

((the doctor is taking notes on the patient's medical history, filling in the patient's record; the patient has her gaze on the record))

- 1 ONC: .h (.) ha malattie particola:ri per cui prende delle medicine?
 .h (.) *do you have particula:r diseases for which you take medicine?* ((he lifts his gaze to the patient, looks rapidly to D and then returns to PAT))

- 2 (0.4) di [qualsiasi tipo?
(0.4) *of [any kind?*
- 3 PAT: [no:: ↓ ((she slowly shakes her head))
- 4 (0.4) ((D looks at PAT))
- 5 ONC: non prende ↓medici[ne.=
you do not take ↓medici[ne.= ((slightly shaking his head))
- 6 PAT: [n°i[ente°: sì=no-
[no°[thing:° yes=no- ((turning toward D))
- 7 D: [co:me non prendi medicine.
[wha:t? *you do not take medicine.* ((to PAT, leaning toward her
and opening her hand as in a questioning gesture))
- 8 PAT: le pr↑e:ndo medicine s[i= però::
I do ↑ta:ke ((turning toward ONC)) *medicine y[es=but*
- 9 ONC: [eh forse
[uh *I'd bet on it* ((opening his hands))
- 10 PAT: quelle della pressio:ne,
those for blood pre:ssure,
- 11 ONC: e↑h >[(quella)< è:
e↑h [>(that one)< is:
- 12 PAT: [per tenerla regolata
[to keep it regular
- 13 ONC: le dò una brutta notizia.
I'll give you some bad news. ((he leans on the table pointing his pen to the patient))
la pressio:ne è una mala↓tti:a eh,
((high)) *pressure is a dis↓eas:e uh,*
- 14 PAT: hh ↑h ((PAT laughs))
- 15 ONC: iperte:sa,
((writing on the record)) *hyperten:sive*

Perhaps considering improbable, on the basis of his experience, that an elderly woman like the patient does not assume any pharmacological treatment (Ritchie, Kvale, & Fisch 2011), the doctor repeats in extenso and by an interrogative form the patient's answer, to solicit a further confirmation from her ("you do not take medicine," Line 5). Indeed, the patient corroborates again her response ("nothing," Line 6), but she gets interrupted by the daughter, who contests her claim (in a questioning postural attitude) and solicits a revision of her declaration. Rushing through the response and overlapping with the daughter's question (Line 8), the patient corrects her answer.

Only after the daughter's turn, who, in this case, plays an essential part in validating the patient's responses, the patient acknowledges that she assumes a specific kind of medicine ("those for high blood pressure," Line 10). Subsequently she continues with a further specification "for keeping it balanced" (Line 12). The patient does not consider her high pressure to be such a "particular" disease, and subsequently qualifies the drugs that she takes as having a different status from the ones the doctor was inquiring about. The doctor teases the patient by telling her that high pressure, in the medical setting, is defined and categorized as a "proper illness" instead (Line 13). After the misunderstanding is cleared, the doctor reformulates the patient's mundane

name of the illness (high pressure) into the medical register (hypertension), the term with which the patient's condition is written up on the patient's record.

Hypertension is often considered by the patients to be scarcely important because of its characteristic of being asymptomatic if kept under control by pharmacological treatments (e.g., “I *only* have high pressure”). On the contrary, for the oncologist it is essential to know whether the patient suffers from high blood pressure, as it is a systemic disease that needs to be taken into account prior to making a decision and beginning an oncological treatment.

The difference between the doctor and the patient regarding what they classify as a “particular” illness constitutes the tension around which the whole anamnesis stage unfolds. For this reason, this stage becomes a paramount opportunity for the doctor to introduce the patient to the systems of relevancies and — even lexical — categorizations, prevailing in medicine in general and oncology in particular.

In the following example, the patient is responding to the doctor's question about existing particular illnesses. After having listed a series of other diseases (osteoporosis, temporary neuropathy occurred after chemotherapy), the patient reports to the doctor the continuous occurrence of the cough as a particularly annoying ailment.

Excerpt 3 — Visit 12 AEM

Participants: Oncologist (ONC), Patient (PAT, female), Husband (HUS)

- 1 PAT: però è da parecchio che ce l'ho, è la tosse, una tosse che c'ho: .h e:
 still something that is quite some time that I have had it, is the cough, a cough
 that I have: .h e:
- 2 ONC: vabbe', quello poi vedremo, perché la tosse, non è una mala-
 well, we'll look at it later on, 'cause the cough is not an ill-
- 3 PAT: no. la tosse ce l'ho, forse, per l'esofagite, perché c'ho anche una:=
 no. I have this cough, maybe, due to the esophagitis, 'cause I have also a:=
- 4 HUS: reflusso,
 reflux,
- 5 PAT: =una un piccolo reflusso, e una piccola ernia iatale.
 =a small reflux, and a small iatal hernia.
- 6 ONC: la tosse non la metto tra le malattie,
 I won't put the cough among the illnesses,
- 7 perché la tosse non è una malattia. la tosse è un sintomo.
 'cause the cough is not an illness. it is a symptom.
- 8 PAT: ah, ha ragione,=
 uh, you're right,=
- 9 HUS: eh già, scu(h)si.
 eh right, so(h)rry.
- 10 PAT: =ha ragione, dottore ma io so' ignorante
 =you're right, doctor but I'm ignorant

This narrative continues as the doctor's attempt to postpone the consideration of the cough as a disturbance is resisted (Line 2). The patient then engages in an explanation about its possible cause (explanation, in which the husband cooperates too) (Lines 3, 4, and 5). The doctor

closes this “multivoiced” explanation with a turn, in which he defines the cough as a symptom and concurrently clarifies the reason why he is not writing down in the record (in that it is a “non-illness”) the information that the patient is telling him. This intervention/procedure of “classifying” an object (the cough) as nonrelevant for the ongoing activity solicits, in turn, the patient’s husband to apologize and the patient herself to provide an account that justifies her lack of knowledge regarding the difference between an illness and a symptom. We might notice that the doctor uses this interaction to introduce and socialize the patient to this distinction that is central for her to properly define her disturbances. It can also be relevant for her to know, in order to develop as a “competent” oncological patient.

In the upcoming example we will analyze an explanation by the doctor regarding the severity of illnesses that afflict the patient. The initial intervention is formatted as a recognizable instructional sequence.

Excerpt 4 — Visit 8 RMMM

Participants: Oncologist (ONC), Patient (PAT, female)

((the doctor has just told the patient that she needs to lose weight))

- 1 ONC: allora le spiego una cosa.
so I will tell you something.
- 2 PAT: sì.
yes.
- 3 ONC: allora=
so=
- 4 PAT: no lo sa perché rido,=
well you don't know why I'm laughing,=
- 5 ONC: =no lei già lo sa,
=well you already know it,
- 6 PAT: =perché io ho già perso tredici chili. ((ride))
= 'cause I've already lost thirteen kilos. ((laughing))
- 7 ONC: eh, vabbe', però ne deve perdere anco(h)ra.
Well, right, still you have to lose mo(h)re.
- 8 PAT: eh,
- 9 ONC: lei c'ha, (.) una cosa che è una scemenza,
you have, (.) something that is a trifle,
- 10 PAT: mh.
- 11 ONC: il tumore della mammella.
breast cancer.
- 12 PAT: sì,
yes,
- 13 ONC: e una cosa che è grave, che è la sindrome metabolica.
and something that is serious, that is metabolic syndrome.
- 14 PAT: mh.
- 15 ONC: che la sindrome metabolica, è. ipertensione, obesità, diabete, e ipercolesterolemia.
and metabolic syndrome is. hypertension, obesity, diabetes, and hypercholesterolemia.

Anticipating the subject of the doctor's explanation, the patient begins an ironic quarrel with him and attempts to stop him from pursuing the argument, telling him that she has already lost a lot of weight. The doctor answers that this is still not enough. In order to emphasize the urgency of attending to the problem of the weight excess, the doctor formulates a "ranking" of the degree of severity of the patient's different illnesses: in this series, the tumor, paradoxically, appears categorized as a trifle, whereas the metabolic syndrome (whose single components are rigorously listed by medical terminology) results the most serious one.

By means of this explanatory and highlighting sequence, where illnesses' classification is done on the basis of their relative degree of severity (which is inverted, as compared to the patient's expectations), the doctor reaches two aims: a short term one is to persuade the patient to not underestimate the metabolic syndrome and to lose further weight; the other one, resting on a longer term, is to build a competent patient who might be better aware of her/his disturbances.

The examples show how the doctor invests upon the development of the patient's competence. Why does he do so? What is the reason for dedicating time to such explanations?

The chronic quality of the oncological illness makes the first visit with new cancer patients the beginning of a relationship, which will last, for most cases, several years (including treatments and follow up visits). For this reason, it is in the doctor's interest to invest in the development of the patient's knowledge regarding the set of relevant categories and terminologies that are used within the oncological field. A competent patient is a better patient, a patient who adheres to the therapeutic recommendations, who signals problems or symptoms he/she experiences more promptly than others, who better masters his/her life as a cancer patient (cf. on this point, also the American Society of Clinical Oncology, ASCO guidelines). Such a patient makes the therapeutic action of the oncologist both effective and efficient (Green McDonald, O'Connell, & Suls, 2015). This socializing activity, which starts right at the beginning of the visit from the apparently simple stage of anamnesis, also continues in further stages when the doctor and the patient engage in the treatment recommendations phase (Alby, Zucchermaglio, & Fatigante, 2016).

Strategic Questions and Competent Answers

Anamnesis is, thus, not merely an almost automatic activity of information recall by the patient regarding his/her clinical history and the disturbances he/she suffers. Rather, anamnesis turns out to be a "crossing" between classification systems and knowledge domains that are distinct for the patient and the doctor. It is a gathering, which requires elaborated forms of collaboration between the participants, and where an important role is played by the participants' respective competences (and incompetence).

First of all, the doctor's expert competence to formulate, in different ways, the question to the patients is in play. In the following example (Excerpt 5), the patient's wife (who speaks on behalf of her voiceless husband (as he had endured a surgery affecting his throat and tongue) responded to the question about the "particular illnesses" referring about diabetes only. Nonetheless, after the doctor's pursuit of more information, she eventually quotes both high blood pressure and episodes of heart arrhythmia. At this point the doctor, after having categorized the woman's reticent behavior as something rather common among patients (Line 1), chooses to change his questioning strategy, explaining the advantages of this to the other participants as well.

- 8 ONC: io pure signora.
so do I madam. ((closing the record and giving it back to the patient, who takes it and puts it in her bag))
- 9 HUS ((laughs))
- 10 PAT: eh mio padre soffriva di ischemia, però gli venivano delle ischemie serie.
eh my father suffered from ischemia, although he got serious ischemic attacks.
- 11 a me mi viene questa forma così:
I get this form like this:
- 12 ONC: vabbe'. allora mettiamo che dalla diagnosi,
alright. so let's put that as regards the diagnosis,
- 13 non s'è capito che cos'è.
they did not understand what it is.
- 14 PAT: non s'è capito che è.
they did not understand what it is.

The patient responds that the outcome of that examination was never defined, and she keeps telling the oncologist that, notwithstanding the lack of ascertained conditions, she often feels “strange.” The ironic comment of the doctor signals that this qualification does not count as relevant (Line 8). The patient continues her narrative, adding other details of her familial clinical history as a further explanation. However, the narrative is again interrupted by the oncologist, who reduces, transforms, and labels the overall problem as a disturbance that cannot be categorized and defined within a medical point of view (as a matter of fact, he does not transcribe it fully in the patient’s clinical record). The patient refers events and disturbances evidently important from her point of view, which, still, remain too vague and imprecise to be useful for anamnesis and the ongoing visit.

Another patient’s behavior (Excerpt 7) shows a totally different case. As she responds to the doctor’s question about whether she habitually takes medicines, the patient tells him that she called home right before the visit and, with the help of her daughter, prepared a list of all the medicines that she currently takes (list, which she promptly takes out from her bag).

Excerpt 7 — Visit 22 SDL

Participants: Oncologist (ONC), Patient (PAT, female)

- 1 ONC: prende abitualmente delle medicine?
do you habitually take medicines?
- 2 (.)
- 3 PAT: e sì. ne prendo una sfilza, perché:
yes I do. ((she bends toward her bag on the ground)) I take tons of them, for:
- 4 ONC: e me la dica la sfilza
so tell me the tons
- 5 PAT: ah ecco. ho fatto bene allora, ho telefonato adesso a mia figlia,
uh here it is. I did the right thing then, I called my daughter just now,
- 6 e gli ho detto <fammi sapere tutto l’elenco,>
and I told her <tell me all the list,>
- 7 ONC: <fammi sapere tutto l’elenco=
<tell me all the list=

- 8 PAT: tutto
everything
- 9 ONC: =delle medicine>
=of the medicines ((mimicking the patient's tone))

This patient has a long and complex clinical history and she is certainly familiarized, more than other patients, with the practices of interactions with doctors and also with the complexity of the anamnestic stage. Her ability to anticipate the potential request of the doctor allowed her to craft a tool (the written list) that helps her not to forget anything relevant. This material artifact warrants that she faces in a more effective and time-efficient way — as compared to other cases — the anamnesis stage.

CONCLUDING REMARKS

We can outline three main results, which contribute to broaden our understanding of patient-doctor interactions in the anamnesis phase.

1) Anamnesis is more than just history “taking.” Anamnesis reveals to be a more complex process than a mere collection of objective information (a sense that the label “history taking” might solicit). Our analyses revealed how anamnesis, rather than being an automatic sequence of brief and polar (yes/no) questions addressed by the doctor to the patient, surfaces as a challenging interpretative activity where participants progressively get a shared sense of what is relevant and important to “tell.” Anamnesis then is a stage in which the doctor and the patient need to collaborate in order to build a framework of relevance (or a sense of salience, as Benner, Sutphen, Leonard, & Day, 2010, call it) to which certain biomedical information — and not others — can be ascribed. It also emerges how the patients can be more or less expert as regards the type of information they expect to provide to the doctor and what they believe useful to select in order to efficaciously contribute to anamnesis. We found that this practice of illness classification between the doctor and the patient shares many similarities with the professional ones that we observed in informal interactions between doctors of different specialties (Alby, Zucchermaglio, & Baruzzo, 2015).

2) Domains of knowledge and practices of medical classification. Why should high blood pressure (moreover, kept balanced by pills) interfere with breast cancer? Patients usually tend to overlook certain illnesses more than others. The question about “particular” illnesses opens up a route toward different interpretations between the patients and the doctor of what “counts” as an illness. For patients, illnesses do not include asymptomatic conditions (e.g., blood pressure), conditions that are part of everyday life (which imply routinized medication, e.g., diabetes), low-rate, intermittent, recent conditions (e.g., arrhythmia), acute events occurring in the past (e.g., TIA). The generic term “illness” does not have a univocal meaning, but rather, it invokes many different interpretations that need, in the course of the visit, to be disentangled and negotiated. Our data show how the systems of medical classification require that they are contextualized with regards to the specific aims of the ongoing activity and the specific characteristics of the patient. Furthermore, we believe more appropriate to talk about practices of classification of illnesses in order to emphasize that what is at stake here is a competent “doing” by the doctor, who engages in

a contextualizing task. The latter is translating static and abstract categories into situated categories and, thus, developing a situated judgment about that particular patient.

3) Anamnesis as a site for patient education and socialization. Health literacy and engagement can improve the patients' compliance with the treatment, the patients' self-management of the illness and the quality of their health outcomes (Coulter & Ellins, 2007). In the first visit patients could be seen as novices entering a new domain of knowledge and practices. Anamnesis is a special site for patient education and socialization, due to the amount of interaction and negotiation between the doctor and the patient (higher than those in other stages of the visit). In particular, we showed how anamnesis is a site for the patient's socialization that involves the development of a sense of what compels most attention from a clinical point of view and the construction of interpretative and classification skills that will help the patient to navigate the complex oncology domain (e.g., understanding priorities, irrelevancies, seriousness of conditions comorbidities, kinds of appropriate inferences). The doctor takes time to develop the patient's expertise considering that their relationship will extend for some years. It is thus an asset for the future. This increasing knowledge can support the patient's compliance to the cure, can allow a more informed participation in therapeutic decisions that will need to be taken in the course of his/her journey across the disease.

NOTES

1. Through an analysis of informal conversations between doctors, Alby, Zuccheromaglio, and Baruzzo (2015) showed that doctors handle complexity, cognitive difficulties, limits of their knowledge by relying on collaborative practices (such as joint interpretation, intersubjective generation and validation of hypotheses, and the postponing of the diagnostic decision). These situated practices of diagnostic decision making are essential, and they work as a warrant for professionals to avoid diagnostic errors.
2. The research project received approval from the Ethical Committees of the hospital where the data were collected as well as from the University of Rome Research Ethics Board. Written informed consent was collected from all participants in the study.

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APPENDIX
TRANSCRIPTION SYMBOLS

:	Colon(s): Extended or stretched sound.
—	Underlining: Vocalic emphasis.
(.)	Micropause: Brief pause of less than (0.2).
(1.2)	Timed pause: Intervals occurring within and between same or different speaker's utterances in tenths of seconds.
(())	Double parentheses: Contextual information.
(don't/won't)	Single parentheses: Transcriptionist doubt (best guess) or (guess/other guess).
.	Period: Falling vocal pitch.
?	Question marks: Rising vocal pitch.
!	Exclamation points: Animated speech tone.
WORD	Caps: Extreme loudness compared to surrounding talk.
[Brackets: Marks the beginning point at which current talk is overlapped by other talk.
↓↑	Arrows: Pitch resets; marked rising and falling shifts in intonation.
=	Equal signs: Latching of contiguous utterances, with no interval or overlap.
◦◦	Degree signs: A passage of talk noticeably softer than surrounding talk.
><	Less than/Greater than signs: Portions of an utterance delivered at a pace noticeably quicker (><) or slower (<>) than surrounding talk.
-	Hyphens: Halting, abrupt cut off of sound or word.
.hhh:	Audible inbreaths.
h h:	Audible outbreaths from such events as laughter, or sigh.
wo(h)rd(h):	Outhbreaths within words.