



Follow-Up Visits in Doctor-Patient Communication: The Vietnamese Case

Huong Nguyen^{1a}, Gavin Austin^{2a}

ARTICLE HISTORY:

Received December 2017
Received in revised form February 2018
Accepted March 2018
Available online March 2018

KEYWORDS:

Doctor-patient communication
Follow-up visits
Vietnamese public hospital system
Cultural context
Conversation analysis

Abstract

In a “follow-up visit”, a patient seeks medical attention for an existing health problem. Using data from the Vietnamese public hospital system, we present a more nuanced analysis of follow-ups in health communication than the one currently available. To be specific, we discriminate between “same follow-ups”, in which the doctor is the same one as in the last visit, and “different follow-ups”, in which the doctor has not treated the patient for their problem before. We then extend existing research on “inappropriate follow-ups”, in which the problem solicitation is more suitable for another type of visit, by teasing out additional typological distinctions within this category of follow-up. We go on to show that same and different follow-ups contrast with each other in terms of the format used for the problem solicitation. The broader implication of our findings is that the structure of a medical visit is not invariant, but is shaped by the cultural context in which it occurs.

© 2018 IJSSCL. All rights reserved.

¹ PhD Candidate, Email: u1081741@umail.usq.edu.au

² PhD, Email: gavin.austin@usq.edu.au (Corresponding Author)

Tel: +6-174-6311934

^a University of Southern Queensland, Australia

1. Introduction

Language does not exist in isolation, but is inevitably embedded within — and, consequently, informed by — its cultural context. In broad terms, the present study investigates this relationship between language and culture within one type of communicative event: the medical consultation. More particularly, we will be concerned with the patient's reason for visiting the doctor, and with the categorization of medical visits on this basis.

Robinson (2006) proposes a typology of reasons why a patient might seek medical attention: for the sake of (i) a new concern (i.e., one which they have not sought treatment for before); (ii) a follow-up concern (i.e., one which the patient has sought treatment for before, and which is now being followed up on); and (iii) a chronic-routine concern (i.e., one which is ongoing and therefore needs to be monitored). Robinson goes on to show that, in a medical visit associated with each of (i) to (iii), the doctor uses a particular format for soliciting information about the patient's health issue. This is an important aspect of doctor-patient interaction because the design of the doctor's question constrains how the patient presents their concern in response, and can even have some bearing on the outcome of the consultation as a whole (Robinson & Heritage, 2005).

In the current study, we focus on medical visits related to concerns of type (ii) above. Although follow-ups have garnered some attention in the literature (e.g., Barone, 2001; Cordella, 2004; Gafaranga & Britten, 2003; Heritage, 2005; Jones & Beach, 2005; Park, 2009; Robinson, 2006), a dedicated and in-depth investigation of this type of medical visit is still required. The present study is intended to fill this gap.

We aim to address this shortfall by examining follow-ups in the cultural context of Vietnam. More specifically, within this context, the focus of our attention will be the institutional environment of the Vietnamese public hospital system. In the first place, this system is a potentially fruitful environment within which to investigate this type of visit because, as noted by Pham (2014), patients in the public hospital

system in this country are not required to — and, therefore, typically do not — make an appointment to see a doctor; rather, they seek medical attention only if and when the need arises. In this relatively fluid scenario, visits of various types seem likely to occur.

Our second reason for selecting the Vietnamese cultural context is that, within studies dealing with doctor-patient discourse in general, it has been somewhat neglected so far. Of the studies that have been done, a few have been conducted overseas (especially in the United States) and the rest in Vietnam. In the overseas context, there has been research into patients' descriptions of depressive symptoms (Fancher, Ton, Le Meyer, Ho, & Paterniti, 2010), cancer screening (Nguyen, Barg, Armstrong, Holmes, & Hornik, 2007), and the utilization of conversational constraints in doctor-patient discourse (Tran, 2009). In the domestic context, scholars have examined the communication styles adopted by doctors (Nguyen, 2012), and the ways in which doctors initiate information-seeking moves in consultations (Pham, 2014). The current study aims to add to this somewhat limited corpus of research on Vietnamese doctor-patient communication, and make coverage of this variety of discourse more representative cross-culturally, and less biased towards Western contexts in particular, as a result (for an example of a study of this type of communication in a non-Western context other than the Vietnamese one, see Odeunmi, 2013).

A key characteristic of extant research on doctor-patient communication in the Vietnamese cultural context is that, so far, no study has employed Conversation Analysis (CA) as its analytical approach (for a detailed overview of how CA has been applied to medical discourse, see Gill & Roberts, 2012). One of the aims of the current study is to address this deficiency.

2. Theoretical Framework

Like other types of medical visit, follow-ups have certain distinctive properties. To begin with, there is the purpose of the visit. Whereas a first visit is devoted mainly to the task of soliciting a new health concern and arriving at a diagnosis, the doctor in a follow-up must assess how well the patient is recovering from the health issue that brought them to hospital in the first place. For example, this could involve

studying the results of a medical test that has been conducted in the interim, and making a plan for the ongoing management of the patient's condition (Cordella, 2004).

Another difference between follow-ups and first visits arises when we examine how the doctor solicits the patient's health concern in each case. The solicitation strategy used in a follow-up has two recurring linguistic characteristics: as an "insider" in relation to this problem, the doctor assumes shared knowledge of the health issue on the part of the patient; and the doctor may also include words or phrases which link the present consultation to the most recent one in which this issue was addressed (Robinson, 2006). We illustrate both of these characteristics in each of Extracts 1 and 2 below. Extract 1 is taken from a surgeon-patient consultation (example from White, 2011; S - surgeon, P - patient).

Extract 1

- 10 S: right_ (.) how's the (0.2) belly been.
 11 P: belly ah: not too ba:d uh:m (.) actually today and yesterday
 12 [pretty good days; uh:m: but i've still had a little
 13 S: [mm
 14 P: = irritation off and on=
 15 S: = [°okay°

Notice that the health problem is named using the noun-phrase "the belly" (line 10). The use of the definite article in this phrase tells us that the doctor is assuming shared knowledge of an existing problem, which in turn constitutes evidence that the present visit is a follow-up. Further support for this possibility comes from the doctor's use of the present perfect "'s been" in their opening question, as this explicitly connects the present consultation to the most recent one in which the same health concern was addressed. The patient's use of the present perfect "'ve had" (line 12) in their response is also consistent with the possibility that this visit is a follow-up.

Extract 2 comes from Robinson's (2006, p. 29)

data from primary-care settings (D - doctor).

Extract 2

- 6 D: How is it?
 7 (0.5)
 8 P: Its fi:ne=its: (0.8) >still a bit< so:re.
 9 but s: alright now.

Consider the doctor's use of the referential pronoun "it" in the question "How is it?" (line 6; cf. the full noun-phrase in "the belly" in Extract 1). This not only indicates that the patient is seeking treatment for an existing problem (i.e., a sore arm) rather than a new one, but also encodes an assumption that the patient will know what this pronoun refers to (i.e., the patient's existing health concern). Thus, the doctor assumes even more sharing of knowledge here than in Extract 1. Note also that the patient uses the same pronoun "it" to refer to their health issue in line 8. Lastly, the use of the time adverbial "now" (line 9; cf. the present perfect "'s been" and "'ve had" in Extract 1) implies a contrast between the condition of the patient's arm at present and at an earlier point in time (i.e., the previous visit) as well. As in Extract 1, this knowledge-sharing plus use of temporally significant items is evidence that the current visit is a follow-up.

In Extracts 1 and 2, we have demonstrated that it is possible to categorize each visit as a follow-up based on certain properties of the doctor's problem solicitation and of the patient's response (since it happened to be aligned with the solicitation). What is less clear, however, is whether the doctor in each case is the same one that attended the patient in their most recent stay in hospital, or a different one. This uncertainty surrounding the status of the treating doctor mirrors the situation in existing research on follow-ups generally. While one can sometimes tell that the doctor in the follow-up is the same one as in the last visit, either because the author simply states this (Heritage, 2005) or because it can be gleaned from information in the extract itself (e.g., Cordella, 2004), more often this attribute of the visit is left implicit (e.g., Barone, 2012; Gafaranga & Britten, 2003; Jones & Beach, 2005; Park, 2009; Robinson, 2006). Granted, the default assumption in this scenario would be that it is indeed the same doctor; however, the alternative possibility cannot be excluded. This same uncertainty also reflects the fact that none of the studies cited above has explored follow-

ups in a dedicated and in-depth way. In particular, although Robinson (2006) devotes some space to this type of visit, it is not the primary focus of his paper.

In the current study, we aim to refine the existing analysis of follow-ups in the literature on medical communication by presenting empirical evidence for distinguishing between “same follow-ups”, in which the doctor is the same one as in the most recent visit, and “different follow-ups”, in which the doctor has not treated the patient for their current health problem before.

3. Methodology

3.1. Participants

In all, 12 general practitioners and 31 of their patients took part. Their identities have been protected using pseudonyms.

3.2. Procedure

Ethical clearance was granted by the University of Southern Queensland. The first author recorded 31 follow-up visits that took place in the Consultation and General Practice Units of two Vietnamese public hospitals between June and August 2016. All told, there were nine same follow-ups and 22 different follow-ups. The data was transcribed in the original Vietnamese by the first author using ELAN software. The extracts included in the current paper were then translated into English by both authors.

The results were investigated both qualitatively and quantitatively. In the qualitative analysis, we have made some use of the conversation-analytic approach; however, as in Extracts 1 and 2 earlier, this is used in order to establish the visit type (e.g., first visit, follow-up) only. The transcription notation adopted in this study is Jeffersonian, except that one symbol (i.e., the hash (#) sign) has been added. The participants in this project often said certain words so rapidly that they were almost inaudible (e.g., the word *không* (“no”) in *Tôi không biết* (“I don’t know”). In an instance like this, the swallowed utterance or part thereof appears within hashes (e.g., *#không#*) in the data extracts.

4. Results

As anticipated at the outset of the study, some follow-ups and different follow-ups occurred in our data. These are considered in turn below in sections 4.1.1 and 4.1.2, respectively. We then look at “inappropriate follow-ups” (to be explained in due course) in section 4.1.3. These three sections comprise the qualitative analysis of our data in section 4.1. Some quantitative analysis is provided after that in section 4.2.

There are three features of the data extracts in this paper that are worth noting. First, the hierarchical structure of Vietnamese society is evident in a large set of kinship terms that are utilized for addressing and referring to others (for more information, see Nguyen et al., 2018). The second feature pertains to the translation of each extract. In morphosyntactic terms (including the use of ellipsis), Vietnamese and English diverge to a considerable degree (Nguyen, 2009). In addition, our main objective in the translations is to effect a balance between the naturalness of the English on one hand and fidelity to the original on the other. For the sake of clarity, we also occasionally add some information that is left implicit in the original. Third, a plus (+) sign is used to concatenate two or more words in the Vietnamese transcription. The other symbols that are conventionally utilized for this purpose (e.g., a period or a hyphen) cannot be used in the current paper, as both have values within the CA transcription system. For consistency, the same symbol is employed for this purpose in the interlinear morpheme glosses.

4.1. Qualitative Analysis

4.1.1. Same Follow-ups

In Extract 3, patient Lan has previously undergone a three-week course of treatment for the same concern (i.e., pain in her shoulder running down her right arm). Doctor Chu wants to assess how well patient Lan is recovering (INT - interrogative, PRT - particle).

Extract 3

1	Chu:	về	có	đỡ	↑không
	(.)	chị		↑Lan?	
	home	PRT	better	INT	
		older+sister	Lan		

- ‘Has it got better while you’ve been at home, Lan?’
- 2 (0.3)
- 3 Lan: về hẳn còn (0.3)
nh- như::c ngay cái đoạn
vai
home it still
pain right PRT part
shoulder
- 4 ni [xuống,]
this downwards
‘I still have pain right in this part of my
shoulder running downwards.’
- 5 Chu: [còn] nhức
nơi vai a,
still hurt in shoulder
PRT
‘Your shoulder still hurts.’
- 6 Lan: ‘nơi vai’
in shoulder
‘Yes.’

Consider how Chu opens the consultation. His question, *Về có đỡ không chị Lan?* (“Has it got better while you’ve been at home, Lan?”, line 1), seeks only a minimal answer concerning Lan’s evaluation of her previous problem. This question constitutes evidence that Extract 3 is a same follow-up. First, there is sharing of information about a problem already known to both interlocutors in the use of subject ellipsis. Ellipsis in general is commonly used to connect the current turn of talk with the one immediately before (Drew, 2013); yet there is no preceding turn in this case. Rather, the subject ellipsis in line 1 indicates that Chu anticipates that Lan will be able to recover the ellipsed referent (i.e., the health concern itself) from the physical context. Second, Chu’s question forges a temporal link between the present consultation and the most recent one via the word *đỡ* (“better”). The use of this word presupposes that Lan not only has something wrong with her health, but also received treatment for it during the previous visit. A similar link is implied by the word *về* (“while you’ve been at home”).

Congruent with Chu’s questioning, Lan then strategically formulates her turn (lines 3-4) in

such a way that she presents herself as a same follow-up patient. To begin with, although her turn construction unit is a nonconforming response to Chu’s question (which seeks only a “yes” or “no” answer), she is able to recover the subject referent that has been ellipsed from Chu’s question. She also uses the words *còn nhức* (“I still have pain”) to contrast with the word *đỡ* (“better”) in Chu’s opening question.

4.1.2. Different Follow-ups

In Extract 4, Doctor Lam is treating patient Phuoc for pain in his head (CLA - classifier, HON - honorific).

Extract 4

- 1 Lam: ô::ng (.) tái+khám?
grandpa follow-up+visit
‘This is a follow-up visit?’
- 2 (0.6)
- 3 Phuoc: tái+khá:m
follow-up+visit
‘Yes.’
- 4 Lam: lờì (.) chừ: ông
đau lrăng?
OK now grandpa
trouble what
‘OK. What seems to be the trouble?’
- 5 (0.6)
- 6 Phuoc: dạ:: (0.2) thưa l bác
(0.2) giữ:: (.) nhúc trong
cái đầ:u
HON HON
doctor now pain
in CLA head
‘I have some pain in my head, doctor.’
- 7 (0.4)
- 8 Lam: l nhứ:c?
pain
‘Pain?’
- 9 (0.7)
- 10 Phuoc: nhúc cái đầ:u
pain CLA head
‘Pain in my head.’

As in Extract 3, the manner in which the doctor frames his opening question is a clue to which type of follow-up visit this is. At the beginning of the consultation, Lam displays his knowledge that this is a follow-up visit (of some sort). This is done via a declarative question (line 1) with unit-final-rising intonation, which communicates a strong epistemic stance towards the information in the question (Heritage, 2012). Lam’s inclusion of this information in his turn suggests that he has read the patient’s medical record — an action which is more likely to occur in a different than same follow-up.

Further evidence that this is a different follow-up comes from Lam’s design of his second question (line 4) plus his uptake (line 8) of Phuoc’s response. After Phuoc’s confirmation treats Lam’s prior knowledge as correct (line 3), he proceeds with a question intended to solicit Phuoc’s previous health concern. In contrast to his opening question (line 1), Lam’s second question expresses a weak epistemic stance towards this concern. There are three main reasons why he may have asked Phuoc this question: (i) he did not read his medical record (e.g., perhaps only receiving the relevant information verbally from the nurse charged with looking after this patient’s record); (ii) he is posing an *examining question* (Athanasiadou, 1991) to test whether Phuoc can name his own complaint; and (iii) he has some knowledge of Phuoc’s concern from his medical record, but wants to hear about it from the patient himself as well. Above, we inferred from Lam’s opening question that he has probably read Phuoc’s medical record, so (i) can be effectively discounted. Possibility (ii) is also ruled out by Lam’s uptake (line 8) of Phuoc’s answer (line 6); specifically, his partial questioning repeat (line 8) suggests that the information is new to him. This leaves (iii) as the most plausible explanation for the weak epistemic stance that Lam expresses in his second question. Our conclusion is that he did not examine this patient on his last visit; hence, this visit is a different follow-up.

4.1.3. Inappropriate Follow-ups

We will now move on to consider “inappropriate follow-ups”, in which the doctor’s problem solicitation is more suitable for another type of visit instead (Robinson,

2006). As stated earlier, our overriding aim in this study was to refine the existing analysis of follow-up visits in the literature by distinguishing between same and different follow-ups. From this standpoint, the inappropriate follow-ups in our data were an adventitious result. However, they are no less valuable for that: as we shall see, we will be able to tease out further typological distinctions within this category of follow-up.

Before we present our own findings, some background information about the Vietnamese public hospital system is necessary. Apart from the operating theatre, there are typically two kinds of room in which doctors examine patients in this type of hospital: the consulting room and the ward (Nguyen et al., 2018). All patients who visit the hospital are sent to the consulting room initially. Here the patient is examined by a doctor and classified as a consulting patient, an inpatient or an outpatient. An inpatient or outpatient then moves to the ward to be re-examined. Once the patient is assigned to the ward, doctors from different units attend to them on a daily basis to monitor their condition.

The inappropriate follow-ups in our data fell into three categories: (i) “same follow-up like first visit”, (ii) “same like different follow-up”, and (iii) “different follow-up like first visit”. We will look at each of these categories in turn. Consider Extract 5 (from Nguyen et al., 2018). Trang is a consulting patient who came to this hospital for treatment of chronic pain six months ago. On that occasion, she bought some traditional medication to take at home. She has come for a follow-up with doctor Quynh to obtain more of it (COP - copula, INT - interrogative, PERF - perfect, PST - past tense).

Extract 5

1	Quynh: O hi? rúa	(0.4) aunt	Ma:i O	Thu ↑Trang, (0.2)	<u>Trang</u>
	INT PRT		Mai aunt	Thu Trang	Trang
2	O O aunt	tới aunt come	đau <u>khá:m+bệnh</u> trouble what hospital	↑chi: ↑ri:? COP PRT	mà ?

- 'You're Mai Thu Trang? What brings you to hospital, Trang?'
- 3 (1.4)
- 4 Trang: đɑ:ɔ rúɑ đɑ:ɔ
 tro:::ng (0.3) toàn
thân luôn (0.4)
 pain COP pain inside
 throughout body PRT
 'I have pain throughout my body.'
- 5 móng+ta:i móng+chân gi:
 là- (.) tróc h(h)ết
 (0.6)
 fingernail toenail all
 COP come+off PRT
 'My fingernails and toenails have all come off.'
- 6 >cái khớp #này# là
 coai+nhu đɑ:ɔ hết ròi<
 CLA joint this COP look
 ache all PERF
 'These joints have been aching for ages.'
- 7 (0.2)
- 8 Quynh: dạ::
 OK
 'OK.'
 ((92 lines deleted))
- 101 Quynh: dạ::: (0.2) co:n
 cũng có điều+trị cho
 O
 yes offspring also
 PST examine for aunt
- 102 ròi con biết mà,
 PERF offspring know PRT
 'Yes, I'm with you, as I've examined you before.'

As can be seen in lines 1-2, doctor Quynh 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 (see below). This infelicitous approach is particularly evident in the question marker *đau chi?* ('what trouble?'). In response, Trang pauses for 1.4 seconds, indicating that she is

having difficulty dealing with Quynh's question. Consistent with Quynh's stance, Trang then produces a *three-part list* (Jefferson, 1990) of current concerns (lines 4-6) as if this were the first time she has met this doctor. The pain in Trang's fingernails, toenails and especially her joints is a long-standing problem which — it turns out later in the extract — was raised with Quynh during her last visit. The conversation continues with the history-taking and examination related to Trang's main concern of patellofemoral arthritis (not shown). It is not until Quynh mentions that she has seen Trang for the same concern before (lines 101-102) that we know this visit is a same follow-up.

While Quynh's opening question in Extract 5 is characteristic of what we might find in a first visit, Extract 6 exemplifies a same follow-up in which the doctor solicits the problem presentation in a manner more in keeping with a different follow-up. Doctor Nam is treating patient Loan in the consulting room for a degenerative spinal condition and knee osteoarthritis.

Extract 6

- 1 Nam: rô:i (.) di:: (0.2)
 à:::~::~: (0.3) đưa tay
 ra đo
 OK aunt
 uh stretch arm out take
- 2 huyét áp di è:::?
 (1.0)
 blood pressure aunt INT
 'OK, please stretch out your arm so that I can take your blood pressure.'
- 3 sáng ni có ún
 thút #huyét#+áp
 Íchura?
 morning this PRT take
 medication hypertension INT
 'Have you taken your medication for hypertension this morning yet?'
- 4 (0.2)
- 5 Loan: dạ có::
 INT already
 'Yes.'
- 6 (0.4)

- 7 Nam: ừ:: (1.0) rúra đợc
 vừa +rời về nhà: (.)
 OK so time last
 at home
- 8 là có lấy thuốc
 uống ỉhông?
 COP PRT get medication
 take INT
 ‘OK. So, did you get some medication
 from us last time, and take it while you
 were at home?’
- 9 Loan: dạ- dạ:: không về
 nhà nơi,i,
 HON no go home PRT
 ‘I didn’t leave the hospital.’
- ((35 lines deleted - the doctor is taking
 the patient’s blood pressure))
- 45 Nam: đi đau vùng ỉmô
 hề::?
 aunt hurt part where INT
 ‘Where does it hurt?’
- 46 (1.1)
- 47 Loan: dạ (.) đả::u (0.2)
 cột số::ng ví à:: (.)
 HON pain
 column spine and uh
- 48 KHỚP là hai
đầu+gú::i
 arthritis COP two knee
 ‘I have a degenerative spinal condition
 and arthritis in both knees.’

Nam opens the visit with a request to take Loan’s blood pressure. As this is a routine activity within the medical visits in our data, we cannot tell from this evidence which type of visit this actually is. The first piece of evidence for this comes in line 3, where Nam asks if Loan has taken her medication for hypertension. This question suggests that he has some knowledge of Loan’s health issues. At the very least, then, this visit seems to be a follow-up visit (of some sort). This conclusion is supported by Loan’s conforming answer (line 5). Evidence that this is, more specifically, a same follow-up comes from Nam’s next question (lines 7-8), in particular the phrase *đợc vừa rồi về nhà* (“while

you were at home”). This phrase suggests that Nam is drawing upon first-hand knowledge of Loan’s health concern rather than accessing information from her medical record.

However, Nam’s question, *Rúra đợc vừa rồi về nhà là có lấy thuốc uống hông?* (“So, did you get some medication from us last time, and take it while you were at home?”), also indicates that Nam did not monitor Loan’s health progress on a daily basis during her previous stay in hospital. In particular, he has not kept an exact record of Loan’s prescriptions, which is considered the responsibility of the attending doctor. This interpretation is corroborated by the way in which Nam begins to elicit the main concern (line 45). His elicitor, *Đi đau vùng mô hề?* (“Where does it hurt?”), expresses an agnostic stance vis-à-vis the precise nature of Loan’s medical condition. In short, although the evidence in line 3 and lines 7-8 in the consultation tells us that this is a same follow-up, Nam’s elicitation of Loan’s presenting concern in line 45 is appropriate for a different follow-up instead.

Our final example is of a different follow-up which opens in the manner of a first visit. In Extract 7, ward patient Vu has just finished one course of treatment. Lam is the treating doctor.

Extract 7

- 1 Lam: rô::i (0.2) anh
 a- (.) đả::u ỉrả:ng?
 so older+brother uh
 trouble what
 ‘So, what seems to be the trouble?’
- 2 (1.0)
- 3 Vu: khớp va:i a bá:c,
 joint shoulder PRT
 doctor
 ‘I have pain in my shoulder joint,
 doctor’
- 4 (0.3)
- 5 Lam: va:i ỏà°?
 shoulder INT
 ‘In your shoulder?’
- 6 Vu: với chổ khuỷu+TA:Y
 ni, (.) với #cái# chầ::n

	and and	in CLA	elbow leg	this		'Which room did you stay in for your last course?'
7	(0.2) left	[trá:i]			19	(0.3)
					20	Vu: <u>đâ:y</u> this 'This one.'
8	Lam: mmm 'Mmm.'	[ừ:::]				
9	(0.6)					
10	#khóp# joint	gối knee	<u>trái</u> left	lha? INT		
						Right at the outset of the consultation, Lam displays a lack of knowledge of Vu's medical history in his use of a general-inquiry question (line 1). This launches the consultation in the manner of a first visit. The question marker <i>đau lả:ng?</i> ("what seems to be the trouble?") encourages Vu to provide some new information about his health condition; however, his 1.0-second pause suggests that he is having difficulty formulating his response (cf. line 3 in Extract 5). Vu's three concerns related to his shoulder joint, elbow, and left kneecap (lines 3, 6) are then disclosed as if they were unknown to Lam. The actual visit type becomes discernible from line 16 onwards, when Vu volunteers an assessment of his recovery (lines 16-17) in order to inform Lam that he has come for treatment before. Lam's non-alternative question (line 18), delivered in terminal overlap with Vu's turn (lines 16-17), communicates his lack of knowledge of Vu's previous treatment. We can conclude that Lam did not treat Vu on his last visit, and that the present visit is a different follow-up.
						In Extracts 5 to 7, three inappropriate follow-ups have been exemplified, the first of which took place in the consulting room and the last in the ward. In each case, the inappropriateness of the doctor's solicitation format can be plausibly attributed to one or more of the challenges faced by doctors in keeping informed about their patients' health problems in Vietnamese public hospitals. To begin with, patients sometimes neglect to bring their medical records with them to the consultation: if this happens, it goes without saying that the doctor will have no information to refer to beforehand. Second, doctors in this system have to deal with a large number of patients each day.
11	(0.2)					
12	Vu: yes 'Yes.'	ạ::				
13	Lam: ni [lên] and this	còn anh CLA older+brother	cái- (0.9) shoulder lift	(0.2) <u>vai</u> <u>giở</u> up		
14	được can	↑không? INT				'How about this shoulder? Can you lift it up?'
15	Vu: [lên] up 'Yes.'					
16	<u>trước</u> được:c= rồi before can so	là mà COP but	giở lên lift come	#không# năm not treatment		
17	bữa+ni now	↑giở lift	[được can PRT	rồ:i] But I can		'Before, I couldn't lift it up. But I can now, thanks to the last course of treatment.'
18	Lam: come	[lên stay	nằm] where	chỗ+↑mô?		

Other challenges are specific to the consulting-room environment itself: while ward doctors examine a given patient daily, consulting-room doctors typically attend to a given patient once

only; and whereas outpatients or inpatients tend to return for a follow-up within a few days, consulting patients do not adhere to a specific timeframe but return anytime they feel it is necessary. Given that patient Trang in Extract 5 especially has come back for a follow-up after a hiatus of six months, it is perhaps not surprising that doctor Quynh should have trouble remembering that she has seen her before.

Within the Vietnamese public hospital system, there is also one difficulty which confronts ward doctors in particular. Whenever a patient is sent to this room, they have to submit their medical record to the receptionist. 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. A difficulty such as this may account for why ward doctors lack the necessary background information about a follow-up patient's problem in some instances.

The institutional environment is pertinent to another feature of Extract 6 too. Notice that, whereas doctor Chu in the same follow-up in Extract 3 solicits patient Lan's assessment of her recovery (presumably in order to gauge the efficacy of the previous treatment), Nam does not do this in Extract 6. Our conjecture is that Nam did not give Loan any treatment himself during her previous hospitalization; rather, he carried out a cursory examination and then referred her to another doctor in the wards. In the course of a discussion between the first author and one participating doctor in this study

on June 20th 2016, it transpired that doctors in the consulting rooms often conduct less thorough examinations of inpatients or outpatients than consulting patients, because inpatients or outpatients will be examined again by other doctors during their stay in hospital. This operational feature of the public hospital system in Vietnam is a possible explanation for Nam's approach to the problem solicitation in this visit.

Lastly, recall that, as a rule, the design of the doctor's question shapes the patient's response. The inappropriate follow-ups in Extracts 5 to 7 illustrate this effect in a compelling way because, in each case, the patient aligns their response with the doctor's question even though this question is incongruent with the actual visit type (see lines 4-6 in Extract 5; lines 47-48 in Extract 6; lines 3, 6-7 in Extract 7).

4.2. Quantitative Analysis

As defined earlier, a same follow-up is a visit in which the doctor is the same one that attended the patient in their most recent visit, while a different follow-up is a visit in which the doctor has not treated the patient for their health problem before. In the present section, we demonstrate that this is not a trivial or pedantic distinction which pertains only to the status of the doctor, but is reflected in a fundamental contrast between the two visit types at the structural level as well.

Consider Table 1. The figure in each cell is the number of visits.

Table 1
The Relationship between Follow-up Type and Solicitation Format

Follow-up type	Solicitation format		
	Appropriate for visit type	Inappropriate for visit type	
		Like opposite follow-up type	Like first visit
Same follow-up (N=9)	5	3	1
Different follow-up (N=22)	9	0	13

A Fisher Exact Test run on this data (within R) found that the relationship between follow-up type and solicitation format was statistically significant ($p = .005$). Hence, same and different follow-ups contrast with each other in

terms of the format used for the problem solicitation.

Two further results are also worthy of discussion, each of which is plausibly attributable to certain characteristics of the

institutional environment in which the consultations took place. First of all, different follow-ups (N=22) greatly outnumbered same follow-ups (N=9). Citing Pham (2014), we mentioned earlier that it is not compulsory in the Vietnamese public hospital system for the patient to make an appointment. From a discussion with one of the participating doctors on June 20th 2016, the first author was able to confirm this, and also learned that a patient who does not make an appointment is routinely allocated to any doctor who might be available. In this light, the presence of different follow-ups in our data does not come as a surprise. Nonetheless, the high proportion of this visit type among all the follow-ups in the data (22/31) is striking, as it suggests that it is the norm for a follow-up patient to be examined by someone else. In addition, a Fisher Exact Test found that different follow-ups (13/22) were much more likely than same follow-ups (1/9) to exhibit the solicitation format appropriate for a first visit ($p = .02$). This finding can be traced to the challenges that doctors face in keeping track of their patients' health issues in this institutional environment.

5. Concluding Remarks

This study has contributed to research on follow-up visits in doctor-patient communication in general in three main ways:

1. We have presented a more fine-grained analysis of follow-ups than the one currently available in the literature concerned with medical discourse. Robinson (2006) only identifies "(appropriate) follow-ups" and "inappropriate follow-ups". Our first advance was to draw a distinction between same and different follow-ups. Second, we used this distinction as the basis for identifying three types of inappropriate follow-ups: (i) "same follow-up like first visit", (ii) "same like different follow-up", and (iii) "different follow-up like first visit".
2. By definition, same and different follow-ups contrast with each other in terms of whether or not the attending doctor has treated the patient before. We have shown that these two types of follow-ups differ from each other not only in terms of the

status of the treating doctor, but also in terms of the format that the doctor uses for the problem solicitation.

3. The advances in (1) and (2) were possible specifically because our study was situated within the institutional environment of the Vietnamese public hospital system. The broader implication of this finding is that the structure of a medical visit is not invariant, but is shaped by the cultural context in which it occurs.

At the same time, advance (3) inevitably implies a limitation of the current set of findings as well. To remedy this, future studies will need to explore the relationship between doctor-patient communication and the cultural context further by examining follow-ups in other such contexts. This initiative could be extended by looking also at how this context might influence other types of medical visit. We suggest that at least some of this research deal specifically with inappropriate follow-ups, as this still remains a relatively under-investigated area within work on medical discourse generally.

Besides the research directions identified above, the present study has implications for medical care itself. In each of the visits analyzed in this paper, we have seen that, regardless of the follow-up type, the doctor's solicitation of the patient's health concern has a significant bearing on how the patient discloses this concern. It was also clear from our data that inappropriate follow-ups are commonplace in Vietnamese public hospitals. The upshot is that there is potential for adverse effects on patient disclosure and, by extension, the outcome of the visit itself (Robinson & Heritage, 2005) within this environment if the doctor uses an inappropriate format in their problem solicitation. Although their discourse actions are, of course, institutionally bound, it is recommended that doctors in the Vietnamese public hospital system endeavor to read the patient's medical record (assuming the patient has brought it with them) before soliciting their health concern. This may help the doctor to treat the patient more effectively. Moreover, it would be easier to implement this recommendation if patients were required to bring their medical records to consultations. Finally, these suggestions should also be

understood to apply to other institutional environments which share relevant characteristics with the one we have investigated in the current study.

References

- Athanasiadou, A. (1991). The discourse functions of questions. *Pragmatics: Quarterly Publication of the International Pragmatics Association*, 1(1), 107-122.
- Barone, S. M. (2012). *Seeking narrative coherence: Doctors' elicitations and patients' narratives in medical encounters* (Unpublished doctoral dissertation). Victoria University of Wellington, New Zealand.
- Cordella, M. (2004). *The dynamic consultation: A discourse analytical study of doctor-patient communication*. Amsterdam, The Netherlands: John Benjamins.
- Drew, P. (2013). Turn design. In J. Sidnell & T. Stivers (Eds.), *The handbook of conversation analysis* (pp. 131-149). Chichester, England: Wiley-Blackwell.
- Fancher, T. L., Ton, H., Le Meyer, O., Ho, T., & Paterniti, D. A. (2010). Discussing depression with Vietnamese American patients. *Journal of Immigrant and Minority Health*, 12(2), 263-266.
- Gafaranga, J., & Britten, N. (2003). Fire away: The opening sequence in general practice consultations. *Family Practice*, 20(3), 242-247.
- Gill, V. T., & Roberts, F. (2012). Conversation analysis in medicine. In J. Sidnell & T. Stivers (Eds.), *The handbook of conversation analysis* (pp. 575-592). Chichester: Wiley-Blackwell.
- Heritage, J. (2005). Conversation analysis and institutional talk. In R. Sanders & K. Fitch (Eds.), *Handbook of language and social interaction* (pp. 103-146). Mahwah, NJ: Lawrence Erlbaum.
- Heritage, J. (2012). Epistemics in action: Action formation and territories of knowledge. *Research on Language and Social Interaction*, 45(1), 1-29.
- Jefferson, G. (1990). List construction as a task and resource. In G. Psathas (Ed.), *Interaction competence* (pp. 63-92). Washington, D.C.: University Press of America.
- Jones, C. M., & Beach, W. A. (2005). "I just wanna know *why*": Patients' attempts and physicians' responses to premature solicitation of diagnostic information. In J. F. Duchan & D. Kovarsky (Eds.) *Diagnosis as cultural practice* (pp. 103-136). Berlin, Germany: Mouton de Gruyter.
- Nguyen, D. H. (2009). Vietnamese. In B. Comrie (Ed.), *The world's major languages* (2nd ed., pp. 677-692). London, England: Routledge.
- Nguyen, D. (2012). *Mot so dac diem giao tiep giua bac si va benh nhan trong qua trinh kham va dieu tri benh tai Trung tam Y hoc hat nhan va Ung buou va cac khoa lam sang tai Benh vien Bach Mai* [Some characteristics of communication between doctors and patients during consultations and treatment at the Nuclear Medicine and Oncology Centre and Clinic wards in Bach Mai Hospital] (Unpublished master's thesis). University of Social Sciences and Humanities, Hanoi, Vietnam.
- Nguyen, G., Barg, F., Armstrong, K., Holmes, J., & Hornik, R. (2007). Cancer and communication in the health care setting: Experiences of older Vietnamese immigrants, a qualitative study. *Journal of General Internal Medicine*, 23(1), 45-50.
- Nguyen, H. T. L., Austin, G., Chau, D. D., Nguyen, H. Q., Nguyen, K. H. B., & Duong, M. T. (2018). Eliciting patients' health concerns in consulting rooms and wards in Vietnamese public hospitals. *International Journal of Applied Linguistics & English Literature*, 7(2), 121-133.
- Odebunmi, A. (2013). Greetings and politeness in doctor-client encounters in Southwestern Nigeria. *International Journal of Society, Culture & Language*, 1(1), 101-117.
- Park, Y. (2009). *Analysing medical discourse: The organization of doctor-patient interaction in Korean primary care settings* (Unpublished doctoral dissertation). University of California, Los Angeles, CA.
- Pham, N. (2014). Linguistic and cultural constraints in Vietnamese general practitioners' act of initiating clinical information-seeking process in first

- encounters with outpatients. *Theory and Practice in Language Studies*, 4(6), 1125-1131.
- Robinson, J. D. (2006). Soliciting patients' presenting concerns. In J. Heritage & D. Maynard (Eds.), *Communication in medical care: Interaction between primary care physicians and patients* (pp. 22-47). Cambridge, England: Cambridge University Press.
- Robinson, J. D. & Heritage, J. (2005). The structure of patients' presenting concerns: The completion relevance of current symptoms. *Social Science & Medicine*, 61(2), 481-493.
- Tran, K. (2009). Examining conversational constraints in Vietnamese patient-doctor communication: A case study. *Xulanexus: Xavier University of Louisiana's Undergraduate Research Journal*, 6(1), 3-20.
- White, S. J. (2011). *A structural analysis of surgeon-patient consultations in clinic settings in New Zealand* (Unpublished doctoral dissertation). University of Otago, Wellington, New Zealand.