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Abstract: Preoperative assessments provide an essential clinical risk assessment aimed at identifying patient risks and requirements prior to surgery. As such they require effective and sensitive information-gathering skills. In addition to physical examination, the preoperative assessment includes a series of routine questions assessing a patient's fitness for surgery. These questions are typically designed to elicit minimal, 'no problem' responses, but patients sometimes produce expanded responses that extend beyond the projected information. Our analysis reveals that troubles-telling is often invoked by both nurses and patients as an effective, patient-centred resource for negotiating the medical relevance of patients' concerns in these contexts.

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Response to Reviewers

We are delighted to see that the reviewers have accepted the manuscript as is and require no further amendments. We would like to thank the reviewers for their detailed and constructive reviews.

As per editor's requirements, we have reinserted identifying information in the manuscript.

Many thanks.

Reviewers' comments

Reviewer #1: The authors have taken into account all the points I made in my review and have skillfully edited/amended the paper so that it now makes a strong and coherent analytic argument, which it was my pleasure to read. I have no further recommendations for revision.

Reviewer #3: The authors' revision and responses to comments are reasonable.

Negotiating relevance in pre-operative assessments

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Highlights

- In preoperative assessments, questions are typically checklist oriented.
- Patients don't always respond within the constraints of checklist questioning.
- Nurses & patients use troubles-telling as a resource for negotiating relevance.
- Troubles-telling is a patient-centred resource for curtailing unnecessary detail.

Negotiating relevance in pre-operative assessments

ABSTRACT

Preoperative assessments provide an essential clinical risk assessment aimed at identifying patient risks and requirements prior to surgery. As such they require effective and sensitive information-gathering skills. In addition to physical examination, the preoperative assessment includes a series of routine questions assessing a patient's fitness for surgery. These questions are typically designed to elicit minimal, 'no problem' responses, but patients sometimes produce expanded responses that extend beyond the projected information. Our analysis reveals that troubles-telling is often invoked by both nurses and patients as an effective, patient-centred resource for negotiating the medical relevance of patients' concerns in these contexts.

Key words: UK; Conversation Analysis; troubles-telling; nurse-patient interaction.

INTRODUCTION

The preoperative assessment (POA) exists in most healthcare systems and is completed prior to planned surgery to ensure that the patient is fully informed about the upcoming procedure and that potential risks for surgery are properly assessed. The POA is part of a perioperative system of care aimed at monitoring and mitigating the associated health and mortality risks as well as reducing cancellations, shortening ‘patient pathways’ to treatment and speeding up post-surgery recovery, all of which in turn improve resource efficiencies (Findlay et al, 2011; Malley et al, 2015).

A range of healthcare professionals may carry out the POA, though in the UK, the role is increasingly allocated to specially trained nurses (Abraham, 2013), who are particularly suited to the communicative / therapeutic demands of the role (Bramhall, 2002; Mottram, 2009).

The POA involves a medical examination and assessment of the patient’s suitability for surgery approximately three weeks before an operation. It comprises routine procedures such as measuring blood pressure and carrying out ECGs, as well as questions about the history of the patient’s health (especially previous surgery/anaesthetics), and about current medication and conditions. Determining fitness for surgery is crucial for patients at risk of adverse outcomes, hence communication is key for the efficacy of POAs (Chan et al, 2011). Poor communication can contribute to, or cause, adverse events in treatment (Lingard et al, 2008) and can exacerbate patient anxiety (Carr et al, 2006; Gilmartin & Wright, 2008). Good communication can reduce patient anxiety prior to surgery (Mottram, 2009; Chan et al, 2011), help manage patient expectations and identify their needs (Malley et al, 2015).

The studies above focus on the communicative role of nurse practitioners in POAs, and often identify their success in providing a ‘holistic’ service of care (Hines et al, 2013: 74), preparing patients psychologically, and identifying potential risks through the gathering of accurate and full data. However, very little existing research on communication in the POA addresses actual interactional data (though see [Benwell & McCreddie, \(2016\)](#); also Jones, (e.g. 2007) on similar hospital admissions processes). The current study opens up this interactional ‘black box’ to closer analytical scrutiny by using conversation analysis to examine exchanges between nurses and patients in the UK health system. Our analysis reveals strategies for efficiently and empathically gathering relevant information from potentially anxious patients. We focus specifically on sequences in which patients give expanded responses to the checklist questions posed by the nurses. Our analysis examines how nurse and patient collaboratively negotiate the relevance of the patient’s expanded response to the immediate institutional agenda of assessing fitness for surgery.

Questioning in medical interaction

Interaction in POAs shares with other medical interactions the property of being a highly question-driven form of interaction (Roter & Hall, 2006; Stivers & Majid, 2007). Questions set the agenda for the patient in relation to both the topical domain and the type of action expected in the response (Stivers & Heritage, 2001). In their design, questions also embody the medical professional’s presuppositions vis-à-vis the patient and their epistemic stance towards the information solicited in the question, as well as setting a preference for the polarity of the response (Heritage, 2010). For example, a question about asthma designed as “you don’t have asthma do you” (Heritage, 2010: 57) seeks confirmation (through the tag

question) of a relatively confident assumption about the patient not having asthma (the epistemic stance displayed by the declarative formatting).

These issues of question design are also influenced by the *type* of medical encounter (e.g. ‘well visits’ vs ‘acute visits’) and the *stage* of the medical encounter (e.g. history taking vs diagnosis). Heritage (2010) explains how they are differently influenced by two key principles: *optimisation* (Heritage, 2002) and *problem attentiveness* (Stivers, 2007).

Optimisation refers to the observation that unless a physician has reason to believe otherwise, they typically formulate their questions to favour “‘no problem” responses’ (Boyd & Heritage, 2006: 162). This is illustrated in the example above, in which the doctor’s question is grammatically designed to favour a ‘no asthma’ response. Boyd & Heritage (2006) show that this is the default principle of medical questioning, evident during medical history taking and routine information gathering appointments (with the notable exception of lifestyle questions relating to smoking and drinking, which are rarely optimised (Heritage, 2010)). In contrast, in acute visits, patients present with a problem for which diagnosis/treatment is sought. In these contexts, *problem attentiveness* dictates that questions relating to the patient’s primary symptoms are designed to presuppose a problem. In the POA, diagnosis/treatment has already been addressed; the function of the POA is to determine that there are no *additional* concerns that might prevent surgery taking place. In other words, the patient’s current health problem is not the focus of the questioning. Thus, the design of the nurses’ questions is not typically problem-attentive but rather is oriented to optimised information gathering.

An additional factor in information gathering/medical history taking is orientation to the routine, ‘checklist’ nature of the interactional task where the *content* of the questions is

governed by a procedure or even an actual form to be filled in. This has consequences for the design of the questions and also for the opening sequence. Specifically, health visitors (Heritage & Sefi, 1992; Raymond, 2010) and nurses (Jones, 2007) are observed to preface the questioning with reference to the bureaucratic, imposed nature of the task. In addition, successive questions are often linked through *and*-prefacing (Heritage & Sorjonen, 1994) or a reduced grammatical form that is anaphorically dependent on the preceding question (Stivers & Heritage, 2001) and marks the question as one in a ‘checklist series’ of questions.

In all this, Heritage (2010: 46) observes that ‘physicians and patients both cooperate and struggle with one another over “what matters” in a given medical context’. In other words, whilst the health professional ultimately decides what information will be recorded on the form, in designing and responding to the questions, both parties are involved in negotiating the value of the information exchanged in relation to the institutional goals of the medical encounter.

Our analysis shows that POA questioning involves a routinized, checklist style of optimised questioning but with some important departures in the patterns of sequence organisation and action-orientation that bear directly on the ‘negotiation of what matters’.

Activities and the institutional agenda

While questions in medical encounters set the agenda for the ongoing talk, patient responses sometimes extend beyond the restrictions imposed by the professional’s optimised first position turn. Stivers & Heritage (2001) suggest that these extended responses are either

expanded answers, which are nonetheless aligned to the checklist agenda, or *narrative expansions*, which fully depart from the checklist agenda and are oriented to the patients' 'lifeworld' (Mishler, 1984) concerns. Expanded answers are oriented to difficulties in responding that prompt additional details but still address the agenda of the question, whereas narrative expansions introduce aspects of the patient's own agenda into the interaction (cf. Nishizaka, 2011; Bonnin, 2014). However, both types of extended response may introduce elements of the patients' lifeworld and both are oriented to as accountable, so the distinction is perhaps one of degree rather than discrete categories of response. Our analysis shows that, in the POA, the alignment or otherwise of a patient's response to the agenda of the nurse's question emerges as a collaborative outcome of the interaction between nurse and patient.

Stivers & Heritage (2001) suggest that narrative expansion displays a progressive transition from formulaic history-taking into interaction that is more conversational in form. Ten Have (1989) discusses a similar mixing of interactional frameworks during GP consultations. However, rather than a transition from one interactional framework to another, he suggests that doctor-patient interaction systematically involves ongoing convergence (Jefferson & Lee, 1981) between two distinct activities (consultation and troubles-telling). Both Stivers & Heritage and ten Have thus demonstrate that participants in medical settings shift between the institutional/medical agenda (history-taking/consultation) and the patient's agenda (narrative/troubles-telling). Our own data shows a similar shifting between the checklist agenda of the pre-operative assessment and the patient's agenda, observable in shifts between the type of checklist oriented Q-A sequences described above and troubles telling, but we argue that the distinction emerges as a *product of negotiation* rather than an a priori property of any particular turn at talk.

Troubles-telling in Medical Encounters

‘Troubles-talk’ refers to a particular kind of extended sequence involving personal disclosure of difficult, intimate or embarrassing episodes or problems (Jefferson, 2015). Crucially, Jefferson & Lee (1981) argue that it is not the content of the talk per se that makes it a troubles-telling but the projected trajectory of the talk and the locally invoked categories for the participants (e.g. troubles-recipient). This is particularly relevant to our analysis as we focus on patients’ extended responses introducing potential health problems. In other words, the content of these responses ‘might be pre-classified as a trouble’ (p.403) but its actual status is a matter of interactional negotiation.

In other medical settings, troubles-telling has been examined as a central activity of the problem attentive phase of the encounter, leading to diagnosis/treatment (Ruusuvuori, 2005, 2007; ten Have, 1989). Questioning in the POA, however, is not typically problem attentive, nor is diagnosis/treatment relevant, as the focus is on ‘fitness for surgery’. Troubles-oriented talk nonetheless occasionally emerges in the context of patients’ expanded responses which potentially challenge their fitness for surgery. In these contexts, the nurses observably orient to the institutional goal of probing for and recording potentially relevant information.

In the analysis that follows we demonstrate how routine preoperative sequences normatively orient to an ‘optimised’ design involving ‘no-problem’ or minimally expanded answers to checklist questions, but that where responses are expanded and dispreferred, troubles-oriented talk may be deployed as a resource for negotiating ‘what matters’ to this local agenda in the context of the epistemic and institutional asymmetries of this particular setting.

DATA AND METHODS

Data from fifteen POAs with six different nurses were audio-recorded from an NHS hospital in Scotland. Ethical permission to audio-record (but not video-record) and transcribe was obtained from the NHS ethics board and informed consent was secured from all participants in advance (via letter). Anonymity for all participants (including third parties) was assured by the alteration of potentially identifying details. The recording equipment was left with the nurses to record their own sessions and they were responsible for confirming consent with patients before the session commenced.

The data are transcribed and analysed using conversation analysis (CA), an approach which studies the sequential patterning of turns at talk to reveal members' understandings of the interaction (Sidnell & Stivers, 2013).

DATA ANALYSIS

In what follows we first demonstrate orientation to optimised checklist questioning before considering examples where patients depart from this normative orientation with dispreferred, expanded responses. We then examine the interactional resources deployed by nurses and patients to negotiate the relevance of these expansions to the medical agenda.

Orientation to features of routine checklists

Robinson (2006) demonstrates how the opening sequences of primary care visits index clinicians' understanding of patients' reasons for the visit. Similarly, in POAs, nurses explicitly frame the interaction by referring to institutional goals of form-filling and information-checking, as in Extract 1 (see also Extract 4, 1.1):

Extract 1

1 Nur: basically the object of it is to make sure you're fit
2 enough to undergo your anaesthetic okay so what we're
3 gonna do is ask yer (.) a load a questions .h (0.4)
4 you've already filled them in but we'll go over them
5 ehm (.) check yer blood pressure and see where we go
6 from there. (.) okay

The nurse's orientation to the process as a bureaucratic requirement is displayed through her use of the institutional first person *plural* subject (Wilson, 1990) and informal, semantically loaded lexical choices ("a load a questions"). Heritage & Sorjonen (1994) suggest that, rather than undermining patient-centredness, invoking the bureaucratic nature of the task distances it from the nurse and preserves the overarching emphasis on affiliative relationship-building.

The subsequent interaction displays the features of a routine, checklist medical encounter, including minimisation, and-prefacing and optimisation. Extract 2 illustrates minimisation in the design of both the nurse's questions and the patient's response.

Extract 2

- 1 Nur: any over the counter drugs any cod liver oils
 2 multivitamins [anything like that no
 3 Pat: [no
 4 (3.0)
 5 Nur: and any recreational drugs at all?=
 6 Pat: =no

The nurse's questions are grammatically reduced polar interrogatives designed to elicit unelaborated yes/no responses. Line 5 also illustrates *and*-prefacing, which invokes the agenda-based character of the question and its status as a "routine next" in a series of questions, thereby also treating the preceding response as unproblematic and sufficient (Heritage & Sorjonen, 1994). In addition, the formulation of the nurse's questions with the indefinite negative polarity item *any* projects a *no* response, conforming to the 'no-problem' orientation of the principle of optimisation (Bolinger, 1956; Heritage et al., 2007).

Extract 3 shows the normative force of the principle of optimisation:

Extract 3

- 1 Nur: right my darlin' we'll start- generally ehm any
 2 restrictions on your walking are you [able to-
 3 Pat: [no (.)
 4 Nur: you're fine
 5 Pat: yep, [other than this just now] no
 6 Nur: [()]

7 Nur: 'right that's fine ° (2.0) two flights of stairs you
8 can do:=

The nurse initially formulates her question with *any* (“any restrictions”) and then moves straight into a reformulation “Are you able to-” in overlap with patient’s minimised preferred response “no”. The overlapped reformulation is repaired to the declarative question “you’re fine” which formulates the upshot of the initial Q-A sequence but switches the polarity of the preferred response. The nurse’s incomplete question seems likely to have been aimed at a reformulation providing an optimised alternative question taking into account the patient’s presenting problem. The patient expansion may also be oriented to the apparent contradiction between the optimised responses and the reported “this just now” or to the switch in polarity of response occasioned by the nurse’s turn design. Crucially, the initial and subsequent formulations are oriented to no-problem outcomes which the patient produces one after the other before qualifying with an expansion (1.5) referring to her current problem with walking. Thus, the patient conforms to the principle of optimisation despite surgery-related problems with walking. In other words, neither participant orients to the POA as problem-attentive.

Departures from ‘routine’ data gathering

In the previous examples, the turns of both patients and nurses were oriented to ‘routine’, minimal, no-problem responses, and the sequence accordingly involved a rapid exchange of turns with little elaboration. Sometimes, however, patients produce dispreferred responses that extend beyond the projected restrictions of the question design. In our data, the nurses’ uptake of patients’ extended responses shows a mixture of information-oriented or troubles-

oriented receipts. Information receipts consist of minimal responses (e.g. ‘right okay’), repetition and pursuit of expansion through contingent questions (Heritage & Sorjonen, 1994). Troubles-oriented receipts consist of empathic acknowledgement or assessment of the trouble *as trouble* (Jefferson, 1984). Our analysis reveals that these different forms of uptake implicitly index the patient’s non-minimal response as either an extended answer aligned to the agenda of the question or as a narrative expansion that has moved away from the medical agenda.

Information-oriented uptake

In the following extract, the patient confirms a slight hearing problem which the nurse follows up with a contingent question about hearing aids (1.5). This contingent question is designed for a yes-no response, but receives a transformative, non-conforming response. Grammatically nonconforming responses index a potential problem with the original question (Raymond, 2003), while transformative answers, resist not just the grammatical design of the question but also the terms or the agenda of the question, and so provide clues to the problems with the direct answer (Stivers & Hayashi, 2010):

Extract 4

- 1 Nur: .h any hearing problems(.)>I’m just fi[lling this form<
 2 Pat: [slightly
 3 Nur: for you]
 4 Pat: slight-] slightly in the right ear
 5 Nur: d’ya wear a hearing aid or anything=
 6 Pat: =err: well they gave me one just in case but it’s- it was
 7 like just to see if it helped

- 8 Nur: ↓right okay
 9 (0.4)
 10 Nur: and do you wear glasses

The patient's transformative answer (1.6) is oriented to difficulties with the potential implications of a simple fitted 'no' response. The contingent question is sequentially positioned to be understood as further probing his deafness and its relevance for surgery. Hence a fitted 'yes' or 'no' response would not merely confirm or disconfirm the hearing aid but would be oriented to the agenda of the extended sequence. The transformative response is designed to resist the implications of this agenda.

The important observation for our analysis is that the nurse's uptake (1.8) takes the form of a composite sequence closing third (SCT) (Schegloff, 2007): "right okay". "[R]ight" is a response token that marks epistemic progression and "okay" marks possible closure by claiming acceptance of the preceding second pair part as responsive to the first. In this way, the nurse orients to the information about the hearing aid as having answered the checklist question (presumably having inferred a likely "no" response). On the other hand, the patient's non-conforming response is a dispreferred SPP and these are typically oriented to as expansion relevant. However, through the SCT and the noticeable absence of sequence expansion, the nurse conveys that the requirements of the checklist question have been met and that expansion of the volunteered information is not relevant. In other words, the nurse resolves the patient's struggle with providing a fitted response by marking the sequence as complete; her SCT simultaneously marks receipt of an answer and signals that the additional detail in the patients' response does not 'matter' to the checklist. The patient correspondingly orients to the sequence as closed. In contrast, in the following extract, the nurse's

information-oriented 3rd position responses are expansion-oriented and elicit further details from the patient.

This extract begins with the nurse's question which has the declarative formatting typical of an optimized question. However, the patient does not respond with the preferred minimal, 'no problem' response for which the question is designed, but offers additional information 'only when I'm running'. This triggers non-minimal post-expansion to elicit further information (a fuller version of this extract is examined in detail later in this paper):

Extract 5

- 1 Nur: so you don't suffer any problems with (.) your chest
 2 no asthma no ↓breathing difficulties that you're aware
 3 of
 4 Pat: only when I'm running
 5 Nur: °only when yer ru:nning°
 6 Pat: 'n then I- I was running last night an' ah couldn't
 7 breathe (.) at all(.)had ta kinda stop and try
 8 an' (.)catch breath
 9 Nur: and how far did had yer run
 10 Pat: £not far£
 11 (0.7)

The mixture of preferred and dispreferred features of the patient's response in line 4 point to the patient's struggle to fit her response to both the immediate sequential context and the overarching institutional agenda. Firstly, it is a disaligned response that reports on breathing difficulties so disagrees with the optimized assumption of the nurse's question. In addition,

similar to extract 4, it is a transformative, non-conforming response to a yes-no question, so indexes a problem with the question. On the other hand, the response remains clearly within the agenda of the question, suggesting that the problem is with the terms of the question. Moreover, although it is a dispreferred, disaligned response, it is *produced* in a preferred format and is prefaced with “only” which minimizes the consequences of the disagreement. This suggests that the patient is implying that the breathlessness is not relevant to her operative safety and hence is still oriented to the principle of optimization at the level of the institutional medical agenda (cf. Lee (2011) on transformative answers and orientation to higher level institutional goals).

The nurse’s quiet third position repetition (1.5) displays the recordable relevance of the information for the checklist but does not implicate sequence closure and elicits further information from the patient (perhaps oriented to the accountability of the preceding dispreferred second). This begins as an *and*-prefaced continuation of the generalized account of the patient’s breathlessness when running, but then the patient self-repairs and initiates a narrative description of a single incident. The patient’s response here is no longer oriented to optimization. Indeed, the narrative potentially constitutes a move away from the agenda of the question. However, it is still topically relevant and the nurse indexes topical coherence by the *and*-prefaced question in line 9 that ties the implications of the narrative back into the checklist activity and receives a more checklist-conforming unelaborated response from the patient. In this way, the relevance of the patient’s responses to the checklist emerges as a negotiated outcome of the patient’s talk and the nurse’s uptake.

Troubles-oriented uptake

The next extract provides a clear contrast with the information-oriented stance of the nurse in

Extracts 4 and 5:

Extract 6

- 1 Nur: can you lie flat on yer back?
- 2 Pat: (0.2).h yes it's not very comfortable with the [(nec
- 3 Nur: [(neck)
- 4 with the reflux=do you ↑get reflux if you lie flat
- 5 then?
- 6 Pat: (0.2)ahh well yes I get (.) eh (0.4) I have tried to
- 7 (.) eh (.) h (0.2) err y'know (.) see y'know err
- 8 what's what's(0.2) happens when [(and things)
- 9 Nur: [yeah
- 10 Pat: y'know (.) with food and with (.) things ah don't know
- 11 whether stress has something to do with it (.) .h ehm
- 12 sometimes when< when this gets really bad it seems to
- 13 go through (.) stages (.) .h but erm if I'm feelin'
- 14 y'know like this (.) erm at night (.) .h erm (.) an'
- 15 when I lie flat I< I have to get up and just bring it
- 16 all up=
- 17 Nur: =mmm=
- 18 Pat: =an' it's just (.) an that's it- ah mean that's what
- 19 ah have to do ta get ta sleep.
- 20 Nur: oh de[ar
- 21 Pat: [yeah an it's- y'know there is the blood an' all the
- 22 [rest of it so
- 23 Nur: [yeah

24 Pat: (.) .hh it's an' it just seems ta (.) once I start (.)
 25 it seems ta just-(0.2)
 26 Nur: keep going=
 27 Pat: =keep going h ah[a
 28 Nur: [°oh dear°
 29 (0.2)
 30 Pat: pff
 31 Nur: (.) .h and (.) how many pillows do you use in your bed?
 32 Pat: (.)err two
 33 Nur: (.)two
 34 (5.0)
 35 Nur: any problem at all with yer blood pressure that yer
 36 know of

This extract begins with a polar interrogative designed for an optimised *yes* response. The patient produces the preferred “yes” but prefaced with a short delay that anticipates the less optimal expansion, “it’s not very comfortable with the (neck)”. This appears to be a reference to the patient’s condition as the nurse produces an overlapping reference to the patient’s problem with reflux and immediately reformulates her question as an upshot of the patient’s ambivalent response. This reformulation (ll.4-5) is *problem attentive*; it does not presuppose a ‘no problem’ response, and the patient begins an expanded response that is hearably populated with numerous hesitations, restarts and vague formulations, though still oriented to the agenda of the question. On line 13, the patient starts to move to a more experience-oriented narrative, prefaced with *sometimes*, but the narrative is still designed to display orientation to the agenda of the question through overt reference to its original wording “when I lie flat” (l.15). At the conclusion of the patient’s narrative, the nurse offers an affiliative and sympathetic acknowledgement of the patient’s talk as troubles-talk, “oh dear”

(1.20), invoking their own status as a troubles-recipient. In this way, the nurse orients to the narrative as a troubles-telling rather than as informative for the POA. The patient follows this first 'oh dear', with a responsive 'yeah' that responds to and overlaps with the nurse's "oh dear" and then a continuation which offers more 'doctorable' features of the condition (1.21: "blood an' all") (Heritage and Robinson, 2006: 57). The nurse however responds with a collaborative completion of the patient's turn "keep going" (1.27) and a second "oh dear", thus still orienting to the patient's description as a troubles-telling. The troubles-oriented sequence is then concluded as the nurse returns to the medical agenda with a related but new 'and-prefaced' question about the number of pillows used by the patient. The nurse's minimal troubles-oriented responses thus convey that the details offered by the patient are not relevant to the immediate medical agenda and so provide a *resource* for negotiating relevance whilst crucially maintaining empathy.

This analysis shows that the 'business at hand' involves information that is sometimes troubles-oriented but is not, in the first instance at least, sequentially produced as a troubles-telling. This is particularly relevant in *problem attentive* medical questioning such as is seen in lines 4-5. The nurse's question about reflux elicits troubles implicative information but as argued by Jefferson and discussed above, it is not the content but the sequential organisation and forms of uptake that mark talk as a troubles-telling. Troubles-telling as an activity is thus invoked by the participants at certain points in the interaction. At these points, participants observably negotiate the institutional/social relevance of the troubles-related talk and the categorial roles and identities implicated therein. In particular, the recognisability of the elements of a troubles-telling sequence appears to provide the participants with a strongly affiliative *resource* for disengaging from the institutional task of information-gathering.

Jefferson (1988) describes the trajectory of troubles-telling in three stages: announcement; exposition; affiliation response. Each stage involves a stepping up of ‘interactional intimacy’ collaboratively negotiated by troubles-teller and troubles-recipient. An initial troubles-oriented uptake of an *announcement* commits the recipient to the locally accomplished status of troubles-recipient and elicits *exposition* of the trouble. This in turn receives *heightened affiliation* by the recipient that elicits further expansion of the troubles-report. It is this further expansion, the *affiliation response*, that is the ‘topical and relational heart of troubles-telling’ (p. 43) and it emerges as a response to the increased level of empathy/affiliation in the uptake of the exposition *relative to the uptake of the initial announcement*.

In our data, troubles-telling is invoked when the nurse orients to a patient response with a display of troubles-recipient. Thus, in extract 6, as the patient moves away from the medical agenda, the nurses’ responses overtly orient to the patients’ talk as a troubles-telling through a display of empathic acknowledgement (“oh dear”). In this way, the nurse orients to the patient’s talk as a troubles-*announcement* and elicits *exposition* of the trouble (1.21). In other words, the initial troubles-oriented uptake by the nurse (line 20) provides the patient with the ‘go-ahead’ to expand their response while also marking it as moving away from the medical agenda.

In so doing, the nurse invokes a shift from her institutional role as nurse to a locally accomplished identity as troubles-recipient. Crucially, the nurse’s troubles-oriented uptake addresses that part of the patient’s response which is affect-oriented rather than receipting the response as information relevant to the history taking. Interestingly, following the nurse’s

initial move to troubles-recipienty, the patient appears to attempt to realign their talk with the information-oriented medical agenda through the repair in line 21 that shifts focus from the experiential to the physical/doctorable (“blood an’ all that”). However, the nurse does not correspondingly revert to information-oriented uptake but responds to the patient’s on-going narrative with a continuer (l.23), an affiliative co-completion (l.26) and finally a second “oh dear” (l.28) which receipts the narrative as a troubles-exposition. In this way, the nurse and patient tease apart information and affect and collaboratively negotiate that the move to troubles-recipienty marks official absence of uptake of the medical/‘doctorable’ information.

However, invoking troubles-recipienty also brings a new and equally delicate task of exiting from the troubles-talk to return to the checklist without appearing to disregard the patient’s concerns. Exiting from troubles talk in other medical settings, e.g. primary care, may be accomplished via institutionally mandated activities such as advice giving or diagnosis and remedy (Ruusuvuori, 2005, 2007). However, such activities are not relevant in the POA which is solely oriented to information gathering. In contrast to the ideal schema that Jefferson describes, the nurses in our data use the *same response form* for the uptake of both announcement and exposition. In other words, the increase in empathy that Jefferson observed to mark the shift from troubles-recipienty to affiliation is *noticeably absent* in the nurse’s responses. Moreover, the patients orient to this noticeable absence of heightened affiliation as closure implicative. In other words, while the first troubles-receipt invites elaboration of the trouble, the repeated receipt format appears to block the move to ‘affiliation response’. Instead the patient (l.30) produces just the very minimal “pff” leaving the nurse free to move the “relevant next” in the medical questioning, a question about pillows.

Whilst the noticeable absence of increased affiliation in the uptake of the exposition of a troubles-telling risks being interpreted as a lack of empathy, or as a ‘synthetic’, professionally mandated empathy, the nurse combines the repetition with a highly local, recipient-designed display of empathy/ intersubjective understanding: the collaborative completion, “keep going” (1.27). In this way, the nurse sensitively accomplishes what might otherwise be seen as a premature exiting from the troubles-telling sequence.

It is striking to note that it is not merely the practice of responding with a troubles-oriented uptake that recurs here and elsewhere in our data but rather the full sequential trajectory:

- A. Pat: extended response
- B. Nur: troubles-oriented uptake
- C. Pat: troubles exposition (with reference to doctorability)
- D. Nur: repeated troubles-oriented uptake (combined with local, recipient-designed display of shared understanding)

For example, in the following extract (analysed in [Benwell & McCreddie, 2016](#)), the nurse repeats the troubles-oriented response “what a shame” (1.7 & 1.10) but also displays shared understanding of the patient’s central concern through repetition of “young”, while the patient following the initial troubles-oriented uptake focuses on the doctorable “strokes” and seizures” in the troubles exposition:

Extract 7

- 1 Pat: =oh I tell a lie my sister (.) my sister who’s younger
- 2 than me has had (.) two strokes in the last year
- 3 Nur: right

- 4 Pat:**A**→ (thought it might be) useful to mention that (0.8)
 5 she's had two strokes she's two years younger than me
 6 she's forty eight [(.) she's had-
 7 Nur:**B**→ [what a shame ↑eh
 8 Pat:**C**→ she's had two strokes yep(.) she's now having (.)
 9 what they think are associated seizures=
 10 Nur:**D**→ =right (0.2) [what a shame
 11 Pat: [so (.) it is a shame
 12 Nur:**D**→ young

Examining our data in light of the detailed stages of Jefferson's candidate troubles-telling sequence thus shows how invoking troubles-telling (B) provides both interactional space for the patient to articulate their concerns (C) but also the resources to exit from the troubles-oriented talk without moving into a full-blown troubles-telling sequence (D). Note that the observation that patients sometimes resist the troubles-telling frame by including overt reference to "doctorable" aspects of their complaint (e.g. Ex.6, l.21) provides participant orientation evidence of the shared understanding of the implications of invoking troubles-telling in these contexts.

On the other hand, closer examination of an expanded version of Extract 5, (given here as Extract 8), suggests that troubles-talk also provides the patient with interactional resources to resist the checklist agenda (cf. Pilnick and Coleman, 2006). As noted above, this sequence begins with a transformative, non-optimal response to the nurse's question about breathing difficulties. This triggers an extended series of information-oriented, contingent questions by the nurse (ll.9, 13, 26) before arriving at the nurse's no-problem summary (ll.34-36):

Extract 8

- 1 Nur: so you don't suffer any problems with (.) your chest
 2 no asthma no ↓breathing difficulties that you're aware
 3 of
 4 Pat: only when I'm running
 5 Nur: °only when yer ru:nning°
 6 Pat: 'n then I- I was running last night an' ah couldn't
 7 breathe (.) at all(.)had ta kinda stop and try
 8 an' (.)catch breath
 9 Nur: and how far did had yer run
 10 Pat: £not far£
 11 (0.7)
 12 Pat: it's terrible ↑isn't it=
 13 Nur: =is that (.) a recent thing? or is that (.) are you
 14 just startin' ta run? [or-
 15 Pat: [I've been running an' then ah
 16 got this problem then I couldn't (.) even walk never
 17 mind run (0.6) so I've not been doing it for a (.)
 18 couple o'weeks
 19 Nur: right (.) o[kay
 20 Pat: [I was doing okay (.) but- I couldn't
 21 believe how (.) short ↑distance I was (like)
 22 (0.5)
 23 Nur: ↓mm kay
 24 Pat: (literally) panic stages (.) I was like that ↑oh my
 25 god I can't breathe but I take it's just unfitness
 26 Nur: and was it like that the ↑first time you started
 27 running?
 28 Pat: (it) ↑↑wasn't as ↑ba:d as that

- 29 Nur: mmm
- 30 Pat: but- (0.8) that's just (to pickle ma head)
- 31 Nur: ahuh heh heh .h okay (0.4) don't have a cough or cold
- 32 at present
- 33 Pat: n:o
- 34 Nur: no (0.2) .h (.) so yer get a bit short of breath on
- 35 (.) moderate exercise but other than that you're not
- 36 short of breath [()]
- 37 Pat: [no

The overall trajectory of the sequence is thus oriented to information gathering and the nurse consistently remains within the interactional framework of the checklist agenda, producing either information receipts or contingent questions. However, the patient's expanded responses move between information-oriented reporting and troubles-oriented narrative. Ten Have (1989) suggests that troubles-telling 'dramatizes the suffering and emotionally involves the teller'. Here, the patient's responses repeatedly display a shift away from the generic temporal reference and information checking of the questions and into more conversational formats involving dramatic combinations of reported thought and extreme case formulations focused on the subjective, situated experience of the patient.

In lines 6-8, the patient begins with an *and*-prefaced continuation of the generalized account of her breathlessness, but then self-repairs and initiates a troubles-oriented narrative description of a single incident in which the problems of breathlessness are produced with an Extreme Case Formulation (ECF) (Pomerantz, 1986) (1.6-7: "couldn't breathe at all"). The nurse responds with an information-oriented contingent question which receives a minimal information-oriented response by the patient who then moves away again from the checklist

agenda, producing a negatively dramatizing assessment (l.12). This realigns the patient's talk with the troubles-talk in lines 6-8 but might also be interpreted as closure implicative, i.e. as an attempt by the patient to close down further probing of her breathlessness as relevant to the POA. (Note, our analysis is hampered here by the lack of video as it is not clear whether the nurse is writing on the form at this point. Ten Have (1989) suggests that troubles-talk occurs in gaps in medical talk where the professional is occupied with other tasks.) The nurse, however, does not respond to the assessment in line 12 and proceeds with information-oriented questioning about the patient's running. The patient complies, providing further information (l.15 – 18) before moving again into narrative expansion with descriptions of reported thought ("I couldn't believe how short distance", "I was like that oh my god I can't breathe") and ECFs ("literally panic stations" "can't breathe").

The suggestion that these troubles-oriented narratives about a specific running experience work up a display of potential non-relevance by the patient is further foregrounded by the patient's assessment, "but I take it's just unfitness" (l.25), which invokes a contrast between fitness issues and medically relevant issues. The minimiser adverb "just" indicates that there is nothing more to say, so is also hearable as closure-implicative (Drew, 1992; Lee & Sheon, 2008). The nurse again does not respond to the assessment but produces a further checklist-oriented, *and*-prefaced question which again receives an informative response (l.28) and another hearably closure-implicative assessment with "just", to which the nurse responds with laughter and an aligned move to close both the topic of running (l.31) and the checklist item about breathlessness (ll.34-36).

There are several interesting recurring features in this sequence. Firstly, the sequence cycles through a recurring pattern in which the patient moves from a report of a potential trouble that is fitted to the checklist agenda to a more conversational narrative that orients to the trouble as relevant to the patient's 'lifeworld' concerns with fitness (Mishler, 1984) before producing a bid for closure. In other words, the patient appears to bring into focus their lifeworld concerns with the impact of their health problem on their fitness and simultaneously display resistance to the immediate medical relevance of those concerns for the POA (cf. Denvir (2012) on the normal/healthy stance enacted by patients in response to substance use history taking). The nurse's uptake on the other hand consistently orients to the informational relevance of the patient's responses for the checklist. This elicits further talk from the patient showing that the nurse's information-oriented uptake is treated by the patient as expansion-relevant. Thus the negotiation of relevance emerges as a collaborative outcome of the patient's troubles-related talk and the nurse's uptake. Moreover the sequential working out of the tension between information-orientation and troubles-orientation evident in this extract indexes the complex layers of epistemic and institutional asymmetry tied to this institutional setting (Sidnell, 2012).

Invoking troubles-telling in patient responses

While the distinction between information-orientation and troubles-orientation is unambiguous in nurses' uptake of patients' responses, the distinction between reporting on potential problems (in line with the checklist) and invoking troubles-telling (moving away from the checklist) in patients' talk is less straightforward. A dispreferred SPP to a checklist question inherently introduces what ten Have (1989) calls a 'report about a self-experienced trouble' but such reports can be, and are, produced without invoking troubles-telling. For

example, the initial report of breathlessness in Extract 8 does not invoke troubles-telling. A report about a potential trouble is argued to become recognisably a troubles-telling when it involves a shift in focus from the trouble to the person (Jefferson, 1980). However, the boundary between focus on the trouble and focus on the person is not always clear. Ten Have (1989) also suggests that troubles-telling is invoked when patients provide more information than is strictly necessary for the medical encounter. Our contention, however, is that ten Have's assessment, 'more information than strictly necessary', is not made from the patient's perspective. Our analysis indicates that patients are typically oriented to providing a response within the agenda of the question (e.g. Ex6, 1.15) but that non-minimal responses and SPP increments index difficulty with providing a fitted response. The data also showed that potentially troubles-oriented responses do not inherently invoke a shift to the activity of troubles-telling.

By contrast, in Extract 8, the patient's SPP increments deploy a range of marked features such as narrative formatting, ECFs and reported thought which offer 'exceptional affordances for empathic alignment' (Heritage, 2011 p. 177) and clearly shift the focus from the trouble to the patient as experiencer of the trouble, invoking a local identity of troubles-teller. Our analysis shows that these overtly troubles-telling elements provide the patient with resources to resist the medical relevance of her concerns. In other words, as with the nurses' troubles-oriented uptake, the patients' more overt shift to troubles-telling marks a shift away from the checklist agenda, as evidenced by the patient's invoked contrast between medical relevance and "just unfitness" (1.25).

CONCLUSION

The POA is a crucial stage of the perioperative process designed to reassure patients and identify potential areas of risk. Putting the patient at ease and providing interactional space for patients to raise health concerns is vital. Our data provided significant evidence that patients sometimes present health information in dispreferred expanded responses whose relevance to the checklist must be collaboratively negotiated.

Nurses orient to these potential reports of trouble either as information pertaining to the checklist, or as a troubles-telling for which an expression of sympathy is relevant. The *locally achieved contrast* between these two types of response, however, is about medical relevance rather than the choice between information-recording versus empathy. Both types of response provide patient-centred resources for curtailing elaboration of unnecessary detail. In extract 4, the nurse's SCT acknowledges the patient's response as relevant and sufficient despite unresolved details in the patient's turn. In extract 6, troubles-oriented uptake of the patient's talk ("oh dear") provides the interactional space for the patient to express their concerns whilst also signalling that the concerns are not surgically relevant. Moreover, the absence of the 'heightened' affiliation that might prompt further disclosure suggests that the nurses are resisting the escalation of such sequences, and reorienting the interaction back to the medical agenda in a way that is nonetheless sensitive and preserves the patients' sense that their concerns are being accommodated.

In extract 8 (also 5), the patient's introduction of troubles-relevant information about her health and lifestyle are notably oriented to by the nurse as potentially medically relevant, but this trajectory is resisted by the patient who develops it as a distinctly troubles-telling

sequence, partially, we argue, to resist the checklist agenda itself. The tension that arises between two agendas here is particularly fascinating. On the one hand, the patient deploys troubles-telling as a resource to *downplay* the medical relevance of her breathlessness, whilst simultaneously prioritising her concern with the lifeworld consequences of her presenting problem. On the other hand, the nurse consistently pursues the potential medical relevance of the breathlessness, presumably due to its possible implication for risk associated with surgery.

Troubles-relevant talk by patients has been observed in other studies of healthcare interaction (ten Have, 1989; Stivers and Heritage, 2001; Ruusuvuori, 2005) and the positive benefits accrued when patients' lifeworld concerns bleed into their medical encounters have been noted (Stivers and Heritage, 2001:158; Robinson and Heritage, 2005: 279; Robinson et al, 2015: 719). By providing troubles-oriented responses to patient disclosures, the nurses in our study conform to this patient-centred ethic and create an affiliative interactional space for patients to express their concerns. However, the evidence from our own data also suggests that troubles-talk is largely prompted where patients struggle to provide a fitted response to information-seeking questions. Nurses engaged in POA information gathering have a potentially tricky path to steer between adhering to the checklist in a time-efficient way, and listening to potential concerns open-mindedly and with empathy. The pursuit of the patient's expanded responses in extract 8 shows that at times nurses depart from an orientation to optimised responses where they feel that such information may reveal clues to medically-relevant concerns. The deployment of troubles-oriented sympathy tokens, on the other hand, are a sensitive and empathic means of signalling digression from the checklist agenda and reorienting the talk accordingly.

Our study provides insight into areas worth highlighting for practitioners engaged in preoperative assessments. A patient-centred approach should allow space for patients to reveal potentially relevant health information, which arguably the optimised design of checklist questions may militate against. The analysis shows how patients sometimes struggle to respond within the constraints imposed by checklist questions and highlights the sensitive means by which patients are afforded space to articulate their concerns whilst non-relevant concerns are curtailed and reoriented. The evidence from the interactions analysed here shows that nurses, in our study at least, are already adept and well-practised in these strategies, and that insights from their talk could inform best practice elsewhere.

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Negotiating relevance in pre-operative assessments

ABSTRACT

Preoperative assessments provide an essential clinical risk assessment aimed at identifying patient risks and requirements prior to surgery. As such they require effective and sensitive information-gathering skills. In addition to physical examination, the preoperative assessment includes a series of routine questions assessing a patient's fitness for surgery. These questions are typically designed to elicit minimal, 'no problem' responses, but patients sometimes produce expanded responses that extend beyond the projected information. Our analysis reveals that troubles-telling is often invoked by both nurses and patients as an effective, patient-centred resource for negotiating the medical relevance of patients' concerns in these contexts.

Key words: UK; Conversation Analysis; troubles-telling; nurse-patient interaction.

INTRODUCTION

The preoperative assessment (POA) exists in most healthcare systems and is completed prior to planned surgery to ensure that the patient is fully informed about the upcoming procedure and that potential risks for surgery are properly assessed. The POA is part of a perioperative system of care aimed at monitoring and mitigating the associated health and mortality risks as well as reducing cancellations, shortening ‘patient pathways’ to treatment and speeding up post-surgery recovery, all of which in turn improve resource efficiencies (Findlay et al, 2011; Malley et al, 2015).

A range of healthcare professionals may carry out the POA, though in the UK, the role is increasingly allocated to specially trained nurses (Abraham, 2013), who are particularly suited to the communicative / therapeutic demands of the role (Bramhall, 2002; Mottram, 2009).

The POA involves a medical examination and assessment of the patient’s suitability for surgery approximately three weeks before an operation. It comprises routine procedures such as measuring blood pressure and carrying out ECGs, as well as questions about the history of the patient’s health (especially previous surgery/anaesthetics), and about current medication and conditions. Determining fitness for surgery is crucial for patients at risk of adverse outcomes, hence communication is key for the efficacy of POAs (Chan et al, 2011). Poor communication can contribute to, or cause, adverse events in treatment (Lingard et al, 2008) and can exacerbate patient anxiety (Carr et al, 2006; Gilmartin & Wright, 2008). Good communication can reduce patient anxiety prior to surgery (Mottram, 2009; Chan et al, 2011), help manage patient expectations and identify their needs (Malley et al, 2015).

The studies above focus on the communicative role of nurse practitioners in POAs, and often identify their success in providing a ‘holistic’ service of care (Hines et al, 2013: 74), preparing patients psychologically, and identifying potential risks through the gathering of accurate and full data. However, very little existing research on communication in the POA addresses actual interactional data (though see Benwell & McCreddie, (2016); also Jones, (e.g. 2007) on similar hospital admissions processes). The current study opens up this interactional ‘black box’ to closer analytical scrutiny by using conversation analysis to examine exchanges between nurses and patients in the UK health system. Our analysis reveals strategies for efficiently and empathically gathering relevant information from potentially anxious patients. We focus specifically on sequences in which patients give expanded responses to the checklist questions posed by the nurses. Our analysis examines how nurse and patient collaboratively negotiate the relevance of the patient’s expanded response to the immediate institutional agenda of assessing fitness for surgery.

Questioning in medical interaction

Interaction in POAs shares with other medical interactions the property of being a highly question-driven form of interaction (Roter & Hall, 2006; Stivers & Majid, 2007). Questions set the agenda for the patient in relation to both the topical domain and the type of action expected in the response (Stivers & Heritage, 2001). In their design, questions also embody the medical professional’s presuppositions vis-à-vis the patient and their epistemic stance towards the information solicited in the question, as well as setting a preference for the polarity of the response (Heritage, 2010). For example, a question about asthma designed as “you don’t have asthma do you” (Heritage, 2010: 57) seeks confirmation (through the tag

question) of a relatively confident assumption about the patient not having asthma (the epistemic stance displayed by the declarative formatting).

These issues of question design are also influenced by the *type* of medical encounter (e.g. ‘well visits’ vs ‘acute visits’) and the *stage* of the medical encounter (e.g. history taking vs diagnosis). Heritage (2010) explains how they are differently influenced by two key principles: *optimisation* (Heritage, 2002) and *problem attentiveness* (Stivers, 2007).

Optimisation refers to the observation that unless a physician has reason to believe otherwise, they typically formulate their questions to favour “‘no problem” responses’ (Boyd & Heritage, 2006: 162). This is illustrated in the example above, in which the doctor’s question is grammatically designed to favour a ‘no asthma’ response. Boyd & Heritage (2006) show that this is the default principle of medical questioning, evident during medical history taking and routine information gathering appointments (with the notable exception of lifestyle questions relating to smoking and drinking, which are rarely optimised (Heritage, 2010)). In contrast, in acute visits, patients present with a problem for which diagnosis/treatment is sought. In these contexts, *problem attentiveness* dictates that questions relating to the patient’s primary symptoms are designed to presuppose a problem. In the POA, diagnosis/treatment has already been addressed; the function of the POA is to determine that there are no *additional* concerns that might prevent surgery taking place. In other words, the patient’s current health problem is not the focus of the questioning. Thus, the design of the nurses’ questions is not typically problem-attentive but rather is oriented to optimised information gathering.

An additional factor in information gathering/medical history taking is orientation to the routine, ‘checklist’ nature of the interactional task where the *content* of the questions is

governed by a procedure or even an actual form to be filled in. This has consequences for the design of the questions and also for the opening sequence. Specifically, health visitors (Heritage & Sefi, 1992; Raymond, 2010) and nurses (Jones, 2007) are observed to preface the questioning with reference to the bureaucratic, imposed nature of the task. In addition, successive questions are often linked through *and*-prefacing (Heritage & Sorjonen, 1994) or a reduced grammatical form that is anaphorically dependent on the preceding question (Stivers & Heritage, 2001) and marks the question as one in a ‘checklist series’ of questions.

In all this, Heritage (2010: 46) observes that ‘physicians and patients both cooperate and struggle with one another over “what matters” in a given medical context’. In other words, whilst the health professional ultimately decides what information will be recorded on the form, in designing and responding to the questions, both parties are involved in negotiating the value of the information exchanged in relation to the institutional goals of the medical encounter.

Our analysis shows that POA questioning involves a routinized, checklist style of optimised questioning but with some important departures in the patterns of sequence organisation and action-orientation that bear directly on the ‘negotiation of what matters’.

Activities and the institutional agenda

While questions in medical encounters set the agenda for the ongoing talk, patient responses sometimes extend beyond the restrictions imposed by the professional’s optimised first position turn. Stivers & Heritage (2001) suggest that these extended responses are either

expanded answers, which are nonetheless aligned to the checklist agenda, or *narrative expansions*, which fully depart from the checklist agenda and are oriented to the patients' 'lifeworld' (Mishler, 1984) concerns. Expanded answers are oriented to difficulties in responding that prompt additional details but still address the agenda of the question, whereas narrative expansions introduce aspects of the patient's own agenda into the interaction (cf. Nishizaka, 2011; Bonnin, 2014). However, both types of extended response may introduce elements of the patients' lifeworld and both are oriented to as accountable, so the distinction is perhaps one of degree rather than discrete categories of response. Our analysis shows that, in the POA, the alignment or otherwise of a patient's response to the agenda of the nurse's question emerges as a collaborative outcome of the interaction between nurse and patient.

Stivers & Heritage (2001) suggest that narrative expansion displays a progressive transition from formulaic history-taking into interaction that is more conversational in form. Ten Have (1989) discusses a similar mixing of interactional frameworks during GP consultations. However, rather than a transition from one interactional framework to another, he suggests that doctor-patient interaction systematically involves ongoing convergence (Jefferson & Lee, 1981) between two distinct activities (consultation and troubles-telling). Both Stivers & Heritage and ten Have thus demonstrate that participants in medical settings shift between the institutional/medical agenda (history-taking/consultation) and the patient's agenda (narrative/troubles-telling). Our own data shows a similar shifting between the checklist agenda of the pre-operative assessment and the patient's agenda, observable in shifts between the type of checklist oriented Q-A sequences described above and troubles telling, but we argue that the distinction emerges as a *product of negotiation* rather than an a priori property of any particular turn at talk.

Troubles-telling in Medical Encounters

‘Troubles-talk’ refers to a particular kind of extended sequence involving personal disclosure of difficult, intimate or embarrassing episodes or problems (Jefferson, 2015). Crucially, Jefferson & Lee (1981) argue that it is not the content of the talk per se that makes it a troubles-telling but the projected trajectory of the talk and the locally invoked categories for the participants (e.g. troubles-recipient). This is particularly relevant to our analysis as we focus on patients’ extended responses introducing potential health problems. In other words, the content of these responses ‘might be pre-classified as a trouble’ (p.403) but its actual status is a matter of interactional negotiation.

In other medical settings, troubles-telling has been examined as a central activity of the problem attentive phase of the encounter, leading to diagnosis/treatment (Ruusuvuori, 2005, 2007; ten Have, 1989). Questioning in the POA, however, is not typically problem attentive, nor is diagnosis/treatment relevant, as the focus is on ‘fitness for surgery’. Troubles-oriented talk nonetheless occasionally emerges in the context of patients’ expanded responses which potentially challenge their fitness for surgery. In these contexts, the nurses observably orient to the institutional goal of probing for and recording potentially relevant information.

In the analysis that follows we demonstrate how routine preoperative sequences normatively orient to an ‘optimised’ design involving ‘no-problem’ or minimally expanded answers to checklist questions, but that where responses are expanded and dispreferred, troubles-oriented talk may be deployed as a resource for negotiating ‘what matters’ to this local agenda in the context of the epistemic and institutional asymmetries of this particular setting.

DATA AND METHODS

Data from fifteen POAs with six different nurses were audio-recorded from an NHS hospital in Scotland. Ethical permission to audio-record (but not video-record) and transcribe was obtained from the NHS ethics board and informed consent was secured from all participants in advance (via letter). Anonymity for all participants (including third parties) was assured by the alteration of potentially identifying details. The recording equipment was left with the nurses to record their own sessions and they were responsible for confirming consent with patients before the session commenced.

The data are transcribed and analysed using conversation analysis (CA), an approach which studies the sequential patterning of turns at talk to reveal members' understandings of the interaction (Sidnell & Stivers, 2013).

DATA ANALYSIS

In what follows we first demonstrate orientation to optimised checklist questioning before considering examples where patients depart from this normative orientation with dispreferred, expanded responses. We then examine the interactional resources deployed by nurses and patients to negotiate the relevance of these expansions to the medical agenda.

Orientation to features of routine checklists

Robinson (2006) demonstrates how the opening sequences of primary care visits index clinicians' understanding of patients' reasons for the visit. Similarly, in POAs, nurses explicitly frame the interaction by referring to institutional goals of form-filling and information-checking, as in Extract 1 (see also Extract 4, 1.1):

Extract 1

1 Nur: basically the object of it is to make sure you're fit
2 enough to undergo your anaesthetic okay so what we're
3 gonna do is ask yer (.) a load a questions .h (0.4)
4 you've already filled them in but we'll go over them
5 ehm (.) check yer blood pressure and see where we go
6 from there. (.) okay

The nurse's orientation to the process as a bureaucratic requirement is displayed through her use of the institutional first person *plural* subject (Wilson, 1990) and informal, semantically loaded lexical choices ("a load a questions"). Heritage & Sorjonen (1994) suggest that, rather than undermining patient-centredness, invoking the bureaucratic nature of the task distances it from the nurse and preserves the overarching emphasis on affiliative relationship-building.

The subsequent interaction displays the features of a routine, checklist medical encounter, including minimisation, and-prefacing and optimisation. Extract 2 illustrates minimisation in the design of both the nurse's questions and the patient's response.

Extract 2

- 1 Nur: any over the counter drugs any cod liver oils
 2 multivitamins [anything like that no
 3 Pat: [no
 4 (3.0)
 5 Nur: and any recreational drugs at all?=
 6 Pat: =no

The nurse's questions are grammatically reduced polar interrogatives designed to elicit unelaborated yes/no responses. Line 5 also illustrates *and*-prefacing, which invokes the agenda-based character of the question and its status as a "routine next" in a series of questions, thereby also treating the preceding response as unproblematic and sufficient (Heritage & Sorjonen, 1994). In addition, the formulation of the nurse's questions with the indefinite negative polarity item *any* projects a *no* response, conforming to the 'no-problem' orientation of the principle of optimisation (Bolinger, 1956; Heritage et al., 2007).

Extract 3 shows the normative force of the principle of optimisation:

Extract 3

- 1 Nur: right my darlin' we'll start- generally ehm any
 2 restrictions on your walking are you [able to-
 3 Pat: [no (.)
 4 Nur: you're fine
 5 Pat: yep, [other than this just now] no
 6 Nur: [()]

7 Nur: 'right that's fine ° (2.0) two flights of stairs you
8 can do:=

The nurse initially formulates her question with *any* (“any restrictions”) and then moves straight into a reformulation “Are you able to-” in overlap with patient’s minimised preferred response “no”. The overlapped reformulation is repaired to the declarative question “you’re fine” which formulates the upshot of the initial Q-A sequence but switches the polarity of the preferred response. The nurse’s incomplete question seems likely to have been aimed at a reformulation providing an optimised alternative question taking into account the patient’s presenting problem. The patient expansion may also be oriented to the apparent contradiction between the optimised responses and the reported “this just now” or to the switch in polarity of response occasioned by the nurse’s turn design. Crucially, the initial and subsequent formulations are oriented to no-problem outcomes which the patient produces one after the other before qualifying with an expansion (1.5) referring to her current problem with walking. Thus, the patient conforms to the principle of optimisation despite surgery-related problems with walking. In other words, neither participant orients to the POA as problem-attentive.

Departures from ‘routine’ data gathering

In the previous examples, the turns of both patients and nurses were oriented to ‘routine’, minimal, no-problem responses, and the sequence accordingly involved a rapid exchange of turns with little elaboration. Sometimes, however, patients produce dispreferred responses that extend beyond the projected restrictions of the question design. In our data, the nurses’ uptake of patients’ extended responses shows a mixture of information-oriented or troubles-

oriented receipts. Information receipts consist of minimal responses (e.g. ‘right okay’), repetition and pursuit of expansion through contingent questions (Heritage & Sorjonen, 1994). Troubles-oriented receipts consist of empathic acknowledgement or assessment of the trouble *as trouble* (Jefferson, 1984). Our analysis reveals that these different forms of uptake implicitly index the patient’s non-minimal response as either an extended answer aligned to the agenda of the question or as a narrative expansion that has moved away from the medical agenda.

Information-oriented uptake

In the following extract, the patient confirms a slight hearing problem which the nurse follows up with a contingent question about hearing aids (1.5). This contingent question is designed for a yes-no response, but receives a transformative, non-conforming response. Grammatically nonconforming responses index a potential problem with the original question (Raymond, 2003), while transformative answers, resist not just the grammatical design of the question but also the terms or the agenda of the question, and so provide clues to the problems with the direct answer (Stivers & Hayashi, 2010):

Extract 4

1 Nur: .h any hearing problems(.)>I'm just fi[lling this form<
2 Pat: [slightly
3 Nur: for you]
4 Pat: slight-] slightly in the right ear
5 Nur: d'ya wear a hearing aid or anything=
6 Pat: =err: well they gave me one just in case but it's- it was
7 like just to see if it helped

- 8 Nur: ↓right okay
- 9 (0.4)
- 10 Nur: and do you wear glasses

The patient's transformative answer (1.6) is oriented to difficulties with the potential implications of a simple fitted 'no' response. The contingent question is sequentially positioned to be understood as further probing his deafness and its relevance for surgery. Hence a fitted 'yes' or 'no' response would not merely confirm or disconfirm the hearing aid but would be oriented to the agenda of the extended sequence. The transformative response is designed to resist the implications of this agenda.

The important observation for our analysis is that the nurse's uptake (1.8) takes the form of a composite sequence closing third (SCT) (Schegloff, 2007): "right okay". "[R]ight" is a response token that marks epistemic progression and "okay" marks possible closure by claiming acceptance of the preceding second pair part as responsive to the first. In this way, the nurse orients to the information about the hearing aid as having answered the checklist question (presumably having inferred a likely "no" response). On the other hand, the patient's non-conforming response is a dispreferred SPP and these are typically oriented to as expansion relevant. However, through the SCT and the noticeable absence of sequence expansion, the nurse conveys that the requirements of the checklist question have been met and that expansion of the volunteered information is not relevant. In other words, the nurse resolves the patient's struggle with providing a fitted response by marking the sequence as complete; her SCT simultaneously marks receipt of an answer and signals that the additional detail in the patients' response does not 'matter' to the checklist. The patient correspondingly orients to the sequence as closed. In contrast, in the following extract, the nurse's

information-oriented 3rd position responses are expansion-oriented and elicit further details from the patient.

This extract begins with the nurse's question which has the declarative formatting typical of an optimized question. However, the patient does not respond with the preferred minimal, 'no problem' response for which the question is designed, but offers additional information 'only when I'm running'. This triggers non-minimal post-expansion to elicit further information (a fuller version of this extract is examined in detail later in this paper):

Extract 5

- 1 Nur: so you don't suffer any problems with (.) your chest
 2 no asthma no ↓breathing difficulties that you're aware
 3 of
 4 Pat: only when I'm running
 5 Nur: °only when yer ru:nning°
 6 Pat: 'n then I- I was running last night an' ah couldn't
 7 breathe (.) at all(.)had ta kinda stop and try
 8 an' (.)catch breath
 9 Nur: and how far did had yer run
 10 Pat: £not far£
 11 (0.7)

The mixture of preferred and dispreferred features of the patient's response in line 4 point to the patient's struggle to fit her response to both the immediate sequential context and the overarching institutional agenda. Firstly, it is a disaligned response that reports on breathing difficulties so disagrees with the optimized assumption of the nurse's question. In addition,

similar to extract 4, it is a transformative, non-conforming response to a yes-no question, so indexes a problem with the question. On the other hand, the response remains clearly within the agenda of the question, suggesting that the problem is with the terms of the question. Moreover, although it is a dispreferred, disaligned response, it is *produced* in a preferred format and is prefaced with “only” which minimizes the consequences of the disagreement. This suggests that the patient is implying that the breathlessness is not relevant to her operative safety and hence is still oriented to the principle of optimization at the level of the institutional medical agenda (cf. Lee (2011) on transformative answers and orientation to higher level institutional goals).

The nurse’s quiet third position repetition (1.5) displays the recordable relevance of the information for the checklist but does not implicate sequence closure and elicits further information from the patient (perhaps oriented to the accountability of the preceding dispreferred second). This begins as an *and*-prefaced continuation of the generalized account of the patient’s breathlessness when running, but then the patient self-repairs and initiates a narrative description of a single incident. The patient’s response here is no longer oriented to optimization. Indeed, the narrative potentially constitutes a move away from the agenda of the question. However, it is still topically relevant and the nurse indexes topical coherence by the *and*-prefaced question in line 9 that ties the implications of the narrative back into the checklist activity and receives a more checklist-conforming unelaborated response from the patient. In this way, the relevance of the patient’s responses to the checklist emerges as a negotiated outcome of the patient’s talk and the nurse’s uptake.

Troubles-oriented uptake

The next extract provides a clear contrast with the information-oriented stance of the nurse in

Extracts 4 and 5:

Extract 6

- 1 Nur: can you lie flat on yer back?
- 2 Pat: (0.2).h yes it's not very comfortable with the [(nec
- 3 Nur: [(neck)
- 4 with the reflux=do you ↑get reflux if you lie flat
- 5 then?
- 6 Pat: (0.2)ahh well yes I get (.) eh (0.4) I have tried to
- 7 (.) eh (.) h (0.2) err y'know (.) see y'know err
- 8 what's what's(0.2) happens when [(and things)
- 9 Nur: [yeah
- 10 Pat: y'know (.) with food and with (.) things ah don't know
- 11 whether stress has something to do with it (.) .h ehm
- 12 sometimes when< when this gets really bad it seems to
- 13 go through (.) stages (.) .h but erm if I'm feelin'
- 14 y'know like this (.) erm at night (.) .h erm (.) an'
- 15 when I lie flat I< I have to get up and just bring it
- 16 all up=
- 17 Nur: =mmm=
- 18 Pat: =an' it's just (.) an that's it- ah mean that's what
- 19 ah have to do ta get ta sleep.
- 20 Nur: oh de[ar
- 21 Pat: [yeah an it's- y'know there is the blood an' all the
- 22 [rest of it so
- 23 Nur: [yeah

24 Pat: (.) .hh it's an' it just seems ta (.) once I start (.)
 25 it seems ta just-(0.2)
 26 Nur: keep going=
 27 Pat: =keep going h ah[a
 28 Nur: [°oh dear°
 29 (0.2)
 30 Pat: pff
 31 Nur: (.) .h and (.) how many pillows do you use in your bed?
 32 Pat: (.)err two
 33 Nur: (.)two
 34 (5.0)
 35 Nur: any problem at all with yer blood pressure that yer
 36 know of

This extract begins with a polar interrogative designed for an optimised *yes* response. The patient produces the preferred “yes” but prefaced with a short delay that anticipates the less optimal expansion, “it’s not very comfortable with the (neck)”. This appears to be a reference to the patient’s condition as the nurse produces an overlapping reference to the patient’s problem with reflux and immediately reformulates her question as an upshot of the patient’s ambivalent response. This reformulation (ll.4-5) is *problem attentive*; it does not presuppose a ‘no problem’ response, and the patient begins an expanded response that is hearably populated with numerous hesitations, restarts and vague formulations, though still oriented to the agenda of the question. On line 13, the patient starts to move to a more experience-oriented narrative, prefaced with *sometimes*, but the narrative is still designed to display orientation to the agenda of the question through overt reference to its original wording “when I lie flat” (l.15). At the conclusion of the patient’s narrative, the nurse offers an affiliative and sympathetic acknowledgement of the patient’s talk as troubles-talk, “oh dear”

(1.20), invoking their own status as a troubles-recipient. In this way, the nurse orients to the narrative as a troubles-telling rather than as informative for the POA. The patient follows this first 'oh dear', with a responsive 'yeah' that responds to and overlaps with the nurse's "oh dear" and then a continuation which offers more 'doctorable' features of the condition (1.21: "blood an' all") (Heritage and Robinson, 2006: 57). The nurse however responds with a collaborative completion of the patient's turn "keep going" (1.27) and a second "oh dear", thus still orienting to the patient's description as a troubles-telling. The troubles-oriented sequence is then concluded as the nurse returns to the medical agenda with a related but new 'and-prefaced' question about the number of pillows used by the patient. The nurse's minimal troubles-oriented responses thus convey that the details offered by the patient are not relevant to the immediate medical agenda and so provide a *resource* for negotiating relevance whilst crucially maintaining empathy.

This analysis shows that the 'business at hand' involves information that is sometimes troubles-oriented but is not, in the first instance at least, sequentially produced as a troubles-telling. This is particularly relevant in *problem attentive* medical questioning such as is seen in lines 4-5. The nurse's question about reflux elicits troubles implicative information but as argued by Jefferson and discussed above, it is not the content but the sequential organisation and forms of uptake that mark talk as a troubles-telling. Troubles-telling as an activity is thus invoked by the participants at certain points in the interaction. At these points, participants observably negotiate the institutional/social relevance of the troubles-related talk and the categorial roles and identities implicated therein. In particular, the recognisability of the elements of a troubles-telling sequence appears to provide the participants with a strongly affiliative *resource* for disengaging from the institutional task of information-gathering.

Jefferson (1988) describes the trajectory of troubles-telling in three stages: announcement; exposition; affiliation response. Each stage involves a stepping up of ‘interactional intimacy’ collaboratively negotiated by troubles-teller and troubles-recipient. An initial troubles-oriented uptake of an *announcement* commits the recipient to the locally accomplished status of troubles-recipient and elicits *exposition* of the trouble. This in turn receives *heightened affiliation* by the recipient that elicits further expansion of the troubles-report. It is this further expansion, the *affiliation response*, that is the ‘topical and relational heart of troubles-telling’ (p. 43) and it emerges as a response to the increased level of empathy/affiliation in the uptake of the exposition *relative to the uptake of the initial announcement*.

In our data, troubles-telling is invoked when the nurse orients to a patient response with a display of troubles-recipientcy. Thus, in extract 6, as the patient moves away from the medical agenda, the nurses’ responses overtly orient to the patients’ talk as a troubles-telling through a display of empathic acknowledgement (“oh dear”). In this way, the nurse orients to the patient’s talk as a troubles-*announcement* and elicits *exposition* of the trouble (1.21). In other words, the initial troubles-oriented uptake by the nurse (line 20) provides the patient with the ‘go-ahead’ to expand their response while also marking it as moving away from the medical agenda.

In so doing, the nurse invokes a shift from her institutional role as nurse to a locally accomplished identity as troubles-recipient. Crucially, the nurse’s troubles-oriented uptake addresses that part of the patient’s response which is affect-oriented rather than receipting the response as information relevant to the history taking. Interestingly, following the nurse’s

initial move to troubles-recipienty, the patient appears to attempt to realign their talk with the information-oriented medical agenda through the repair in line 21 that shifts focus from the experiential to the physical/doctorable (“blood an’ all that”). However, the nurse does not correspondingly revert to information-oriented uptake but responds to the patient’s on-going narrative with a continuer (l.23), an affiliative co-completion (l.26) and finally a second “oh dear” (l.28) which receipts the narrative as a troubles-exposition. In this way, the nurse and patient tease apart information and affect and collaboratively negotiate that the move to troubles-recipienty marks official absence of uptake of the medical/‘doctorable’ information.

However, invoking troubles-recipienty also brings a new and equally delicate task of exiting from the troubles-talk to return to the checklist without appearing to disregard the patient’s concerns. Exiting from troubles talk in other medical settings, e.g. primary care, may be accomplished via institutionally mandated activities such as advice giving or diagnosis and remedy (Ruusuvuori, 2005, 2007). However, such activities are not relevant in the POA which is solely oriented to information gathering. In contrast to the ideal schema that Jefferson describes, the nurses in our data use the *same response form* for the uptake of both announcement and exposition. In other words, the increase in empathy that Jefferson observed to mark the shift from troubles-recipienty to affiliation is *noticeably absent* in the nurse’s responses. Moreover, the patients orient to this noticeable absence of heightened affiliation as closure implicative. In other words, while the first troubles-receipt invites elaboration of the trouble, the repeated receipt format appears to block the move to ‘affiliation response’. Instead the patient (l.30) produces just the very minimal “pff” leaving the nurse free to move the “relevant next” in the medical questioning, a question about pillows.

Whilst the noticeable absence of increased affiliation in the uptake of the exposition of a troubles-telling risks being interpreted as a lack of empathy, or as a ‘synthetic’, professionally mandated empathy, the nurse combines the repetition with a highly local, recipient-designed display of empathy/ intersubjective understanding: the collaborative completion, “keep going” (1.27). In this way, the nurse sensitively accomplishes what might otherwise be seen as a premature exiting from the troubles-telling sequence.

It is striking to note that it is not merely the practice of responding with a troubles-oriented uptake that recurs here and elsewhere in our data but rather the full sequential trajectory:

- A. Pat: extended response
- B. Nur: troubles-oriented uptake
- C. Pat: troubles exposition (with reference to doctorability)
- D. Nur: repeated troubles-oriented uptake (combined with local, recipient-designed display of shared understanding)

For example, in the following extract (analysed in Benwell & McCreddie, 2016), the nurse repeats the troubles-oriented response “what a shame” (1.7 & 1.10) but also displays shared understanding of the patient’s central concern through repetition of “young”, while the patient following the initial troubles-oriented uptake focuses on the doctorable “strokes” and seizures” in the troubles exposition:

Extract 7

- 1 Pat: =oh I tell a lie my sister (.) my sister who’s younger
- 2 than me has had (.) two strokes in the last year
- 3 Nur: right

- 4 Pat:**A**→ (thought it might be) useful to mention that (0.8)
 5 she's had two strokes she's two years younger than me
 6 she's forty eight [(.) she's had-
 7 Nur:**B**→ [what a shame ↑eh
 8 Pat:**C**→ she's had two strokes yep(.) she's now having (.)
 9 what they think are associated seizures=
 10 Nur:**D**→ =right (0.2) [what a shame
 11 Pat: [so (.) it is a shame
 12 Nur:**D**→ young

Examining our data in light of the detailed stages of Jefferson's candidate troubles-telling sequence thus shows how invoking troubles-telling (B) provides both interactional space for the patient to articulate their concerns (C) but also the resources to exit from the troubles-oriented talk without moving into a full-blown troubles-telling sequence (D). Note that the observation that patients sometimes resist the troubles-telling frame by including overt reference to "doctorable" aspects of their complaint (e.g. Ex.6, l.21) provides participant orientation evidence of the shared understanding of the implications of invoking troubles-telling in these contexts.

On the other hand, closer examination of an expanded version of Extract 5, (given here as Extract 8), suggests that troubles-talk also provides the patient with interactional resources to resist the checklist agenda (cf. Pilnick and Coleman, 2006). As noted above, this sequence begins with a transformative, non-optimal response to the nurse's question about breathing difficulties. This triggers an extended series of information-oriented, contingent questions by the nurse (ll.9, 13, 26) before arriving at the nurse's no-problem summary (ll.34-36):

Extract 8

- 1 Nur: so you don't suffer any problems with (.) your chest
 2 no asthma no ↓breathing difficulties that you're aware
 3 of
 4 Pat: only when I'm running
 5 Nur: °only when yer ru:nning°
 6 Pat: 'n then I- I was running last night an' ah couldn't
 7 breathe (.) at all(.)had ta kinda stop and try
 8 an' (.)catch breath
 9 Nur: and how far did had yer run
 10 Pat: £not far£
 11 (0.7)
 12 Pat: it's terrible ↑isn't it=
 13 Nur: =is that (.) a recent thing? or is that (.) are you
 14 just startin' ta run? [or-
 15 Pat: [I've been running an' then ah
 16 got this problem then I couldn't (.) even walk never
 17 mind run (0.6) so I've not been doing it for a (.)
 18 couple o'weeks
 19 Nur: right (.) o[kay
 20 Pat: [I was doing okay (.) but- I couldn't
 21 believe how (.) short ↑distance I was (like)
 22 (0.5)
 23 Nur: ↓mm kay
 24 Pat: (literally) panic stages (.) I was like that ↑oh my
 25 god I can't breathe but I take it's just unfitness
 26 Nur: and was it like that the ↑first time you started
 27 running?
 28 Pat: (it) ↑↑wasn't as ↑ba:d as that

- 29 Nur: mmm
- 30 Pat: but- (0.8) that's just (to pickle ma head)
- 31 Nur: ahuh heh heh .h okay (0.4) don't have a cough or cold
- 32 at present
- 33 Pat: n:o
- 34 Nur: no (0.2) .h (.) so yer get a bit short of breath on
- 35 (.) moderate exercise but other than that you're not
- 36 short of breath [()]
- 37 Pat: [no

The overall trajectory of the sequence is thus oriented to information gathering and the nurse consistently remains within the interactional framework of the checklist agenda, producing either information receipts or contingent questions. However, the patient's expanded responses move between information-oriented reporting and troubles-oriented narrative. Ten Have (1989) suggests that troubles-telling 'dramatizes the suffering and emotionally involves the teller'. Here, the patient's responses repeatedly display a shift away from the generic temporal reference and information checking of the questions and into more conversational formats involving dramatic combinations of reported thought and extreme case formulations focused on the subjective, situated experience of the patient.

In lines 6-8, the patient begins with an *and*-prefaced continuation of the generalized account of her breathlessness, but then self-repairs and initiates a troubles-oriented narrative description of a single incident in which the problems of breathlessness are produced with an Extreme Case Formulation (ECF) (Pomerantz, 1986) (l.6-7: "couldn't breathe at all"). The nurse responds with an information-oriented contingent question which receives a minimal information-oriented response by the patient who then moves away again from the checklist

agenda, producing a negatively dramatizing assessment (l.12). This realigns the patient's talk with the troubles-talk in lines 6-8 but might also be interpreted as closure implicative, i.e. as an attempt by the patient to close down further probing of her breathlessness as relevant to the POA. (Note, our analysis is hampered here by the lack of video as it is not clear whether the nurse is writing on the form at this point. Ten Have (1989) suggests that troubles-talk occurs in gaps in medical talk where the professional is occupied with other tasks.) The nurse, however, does not respond to the assessment in line 12 and proceeds with information-oriented questioning about the patient's running. The patient complies, providing further information (l.15 – 18) before moving again into narrative expansion with descriptions of reported thought ("I couldn't believe how short distance", "I was like that oh my god I can't breathe") and ECFs ("literally panic stations" "can't breathe").

The suggestion that these troubles-oriented narratives about a specific running experience work up a display of potential non-relevance by the patient is further foregrounded by the patient's assessment, "but I take it's just unfitness" (l.25), which invokes a contrast between fitness issues and medically relevant issues. The minimiser adverb "just" indicates that there is nothing more to say, so is also hearable as closure-implicative (Drew, 1992; Lee & Sheon, 2008). The nurse again does not respond to the assessment but produces a further checklist-oriented, *and*-prefaced question which again receives an informative response (l.28) and another hearably closure-implicative assessment with "just", to which the nurse responds with laughter and an aligned move to close both the topic of running (l.31) and the checklist item about breathlessness (ll.34-36).

There are several interesting recurring features in this sequence. Firstly, the sequence cycles through a recurring pattern in which the patient moves from a report of a potential trouble that is fitted to the checklist agenda to a more conversational narrative that orients to the trouble as relevant to the patient's 'lifeworld' concerns with fitness (Mishler, 1984) before producing a bid for closure. In other words, the patient appears to bring into focus their lifeworld concerns with the impact of their health problem on their fitness and simultaneously display resistance to the immediate medical relevance of those concerns for the POA (cf. Denvir (2012) on the normal/healthy stance enacted by patients in response to substance use history taking). The nurse's uptake on the other hand consistently orients to the informational relevance of the patient's responses for the checklist. This elicits further talk from the patient showing that the nurse's information-oriented uptake is treated by the patient as expansion-relevant. Thus the negotiation of relevance emerges as a collaborative outcome of the patient's troubles-related talk and the nurse's uptake. Moreover the sequential working out of the tension between information-orientation and troubles-orientation evident in this extract indexes the complex layers of epistemic and institutional asymmetry tied to this institutional setting (Sidnell, 2012).

Invoking troubles-telling in patient responses

While the distinction between information-orientation and troubles-orientation is unambiguous in nurses' uptake of patients' responses, the distinction between reporting on potential problems (in line with the checklist) and invoking troubles-telling (moving away from the checklist) in patients' talk is less straightforward. A dispreferred SPP to a checklist question inherently introduces what ten Have (1989) calls a 'report about a self-experienced trouble' but such reports can be, and are, produced without invoking troubles-telling. For

example, the initial report of breathlessness in Extract 8 does not invoke troubles-telling. A report about a potential trouble is argued to become recognisably a troubles-telling when it involves a shift in focus from the trouble to the person (Jefferson, 1980). However, the boundary between focus on the trouble and focus on the person is not always clear. Ten Have (1989) also suggests that troubles-telling is invoked when patients provide more information than is strictly necessary for the medical encounter. Our contention, however, is that ten Have's assessment, 'more information than strictly necessary', is not made from the patient's perspective. Our analysis indicates that patients are typically oriented to providing a response within the agenda of the question (e.g. Ex6, 1.15) but that non-minimal responses and SPP increments index difficulty with providing a fitted response. The data also showed that potentially troubles-oriented responses do not inherently invoke a shift to the activity of troubles-telling.

By contrast, in Extract 8, the patient's SPP increments deploy a range of marked features such as narrative formatting, ECFs and reported thought which offer 'exceptional affordances for empathic alignment' (Heritage, 2011 p. 177) and clearly shift the focus from the trouble to the patient as experiencer of the trouble, invoking a local identity of troubles-teller. Our analysis shows that these overtly troubles-telling elements provide the patient with resources to resist the medical relevance of her concerns. In other words, as with the nurses' troubles-oriented uptake, the patients' more overt shift to troubles-telling marks a shift away from the checklist agenda, as evidenced by the patient's invoked contrast between medical relevance and "just unfitness" (1.25).

CONCLUSION

The POA is a crucial stage of the perioperative process designed to reassure patients and identify potential areas of risk. Putting the patient at ease and providing interactional space for patients to raise health concerns is vital. Our data provided significant evidence that patients sometimes present health information in dispreferred expanded responses whose relevance to the checklist must be collaboratively negotiated.

Nurses orient to these potential reports of trouble either as information pertaining to the checklist, or as a troubles-telling for which an expression of sympathy is relevant. The *locally achieved contrast* between these two types of response, however, is about medical relevance rather than the choice between information-recording versus empathy. Both types of response provide patient-centred resources for curtailing elaboration of unnecessary detail. In extract 4, the nurse's SCT acknowledges the patient's response as relevant and sufficient despite unresolved details in the patient's turn. In extract 6, troubles-oriented uptake of the patient's talk ("oh dear") provides the interactional space for the patient to express their concerns whilst also signalling that the concerns are not surgically relevant. Moreover, the absence of the 'heightened' affiliation that might prompt further disclosure suggests that the nurses are resisting the escalation of such sequences, and reorienting the interaction back to the medical agenda in a way that is nonetheless sensitive and preserves the patients' sense that their concerns are being accommodated.

In extract 8 (also 5), the patient's introduction of troubles-relevant information about her health and lifestyle are notably oriented to by the nurse as potentially medically relevant, but this trajectory is resisted by the patient who develops it as a distinctly troubles-telling

sequence, partially, we argue, to resist the checklist agenda itself. The tension that arises between two agendas here is particularly fascinating. On the one hand, the patient deploys troubles-telling as a resource to *downplay* the medical relevance of her breathlessness, whilst simultaneously prioritising her concern with the lifeworld consequences of her presenting problem. On the other hand, the nurse consistently pursues the potential medical relevance of the breathlessness, presumably due to its possible implication for risk associated with surgery.

Troubles-relevant talk by patients has been observed in other studies of healthcare interaction (ten Have, 1989; Stivers and Heritage, 2001; Ruusuvuori, 2005) and the positive benefits accrued when patients' lifeworld concerns bleed into their medical encounters have been noted (Stivers and Heritage, 2001:158; Robinson and Heritage, 2005: 279; Robinson et al, 2015: 719). By providing troubles-oriented responses to patient disclosures, the nurses in our study conform to this patient-centred ethic and create an affiliative interactional space for patients to express their concerns. However, the evidence from our own data also suggests that troubles-talk is largely prompted where patients struggle to provide a fitted response to information-seeking questions. Nurses engaged in POA information gathering have a potentially tricky path to steer between adhering to the checklist in a time-efficient way, and listening to potential concerns open-mindedly and with empathy. The pursuit of the patient's expanded responses in extract 8 shows that at times nurses depart from an orientation to optimised responses where they feel that such information may reveal clues to medically-relevant concerns. The deployment of troubles-oriented sympathy tokens, on the other hand, are a sensitive and empathic means of signalling digression from the checklist agenda and reorienting the talk accordingly.

Our study provides insight into areas worth highlighting for practitioners engaged in preoperative assessments. A patient-centred approach should allow space for patients to reveal potentially relevant health information, which arguably the optimised design of checklist questions may militate against. The analysis shows how patients sometimes struggle to respond within the constraints imposed by checklist questions and highlights the sensitive means by which patients are afforded space to articulate their concerns whilst non-relevant concerns are curtailed and reoriented. The evidence from the interactions analysed here shows that nurses, in our study at least, are already adept and well-practised in these strategies, and that insights from their talk could inform best practice elsewhere.

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Negotiating relevance in pre-operative assessments

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