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Problem presentation in Iranian secondary care consultations: a conversation analytic study of doctor-patient interactions

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ABSTRACT

Problem presentation plays a vital role in healthcare communication by facilitating treatment and providing interactional opportunities for patients to maximize their participation, thereby leading to patient satisfaction and positive outcomes from the patient's perspective. Drawing on insights from secondary care consultations in Iran and using conversation analysis as the method and approach, this study demonstrates how doctors and patients interactionally achieve this socio-medical activity during doctor-patient interactions. The data consist of 40 audio-recorded and transcribed consultation visits following CA transcription conventions. The study offers detailed analyses of selected excerpts of data to show how talk unfolds and how diagnostic test results shape the verbal presentation of problems. It also provides implications for cross-cultural understanding of doctor-patient interactions.

1. Introduction

Despite technological advancements over the past four decades that provide objective, reliable tools for evaluating treatment outcomes (Roberts et al., 2004), the ongoing focus on problem presentation as a crucial part of medical consultations underscores its vital role in effective treatment. Research shows that clear, effective communication of medical problems improves health outcomes and boosts patient satisfaction with medical visits (Gill & Roberts, 2012; Heritage & Clayman, 2010; Stivers & Tate, 2023). In modern healthcare systems that prioritize patient participation, patient satisfaction during consultations is increasingly significant. From this perspective, problem presentation becomes a key activity, giving patients a platform to increase their engagement in the treatment process. This opportunity allows patients to share their subjective illness theories (Birkner, 2006), suggest differential diagnoses (Bergh, 1998), or voice other concerns related to their illness (Heritage & Robinson, 2006b).

Studies also show that patients' problem presentations significantly influence subsequent diagnostic and treatment activities (Ijäs-Kallio et al., 2011; cf. McCabe, 2021, for mental problems). A thorough and appropriate problem presentation contributes to the overall effectiveness of medical consultations. Although there is no consensus on what constitutes a complete and appropriate problem presentation (Heritage & Clayman, 2010; Heritage & Robinson, 2006a; Robinson & Heritage, 2005), conversation analysis (CA) of medical interactions in acute primary care suggests that these interactions have an internal organizational structure, and understanding the social actions constituting problem presentation is crucial for grasping the normative organization of this activity as a socio-medical practice (Heritage & Robinson, 2006a; Robinson & Heritage, 2005).

However, CA-driven research on medical interactions and problem presentations suffers from two shortcomings: first, it relies predominantly on data in English or, to a lesser extent, other European languages (cf. Barnes & Woods, 2024). A recent systematic review of research on DPI in both primary and secondary care indicates that English predominates the experimental data that inform observations and investigations in the field (Barnes & Woods, 2024). Furthermore, research on healthcare communication has primarily focused on primary rather than secondary care settings, leaving our understanding of specialized care quite limited (cf. Ekberg et al., 2024). Interactions in specialized care feature an internal structure unique to that setting, which might differ from primary care and other specialties (Beach, 2019; Ekberg et al., 2024).

Addressing these gaps and building on a growing body of research on communication in non-English secondary care (Galatolo & Fasulo, 2022), this study examines problem presentation in Persian-language

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secondary care consultations. Using Institutional Conversation Analysis (ICA: Drew, 2003; Heritage, 2004), the study empirically investigates "the normative organization of problem presentation as a socio-medical activity that shapes participants' understandings of what is to be presented, how it is to be presented, and what constitutes a complete presentation" (Robinson & Heritage, 2005, p. 482; cf. Robinson, 2003) in secondary care consultations. Hence, it contributes to a deeper understanding of how the context of medical interviews in Iranian secondary care consultations is 'talked into being' (Heritage, 1984; Heritage & Maynard, 2006; Robinson, 2012).

2. Problem presentation: Review of research and theoretical foundations

Doctor-patient interactions are crucial to healthcare communication, with medical consultations serving as the primary setting for these exchanges. Research in primary care shows that patients see physicians for routine check-ups, managing chronic conditions, follow-ups on illnesses and treatments, and addressing acute illnesses. These categories shape the structure and flow of the interaction (Heritage & Robinson, 2006a). The typical discourse structure of acute care consultations includes six sequential phases: opening, problem presentation, history taking, document checks and physical examination, diagnosis, treatment recommendations, and closing (Robinson, 2003; Robinson & Heritage, 2005). Problem presentation is the first task-oriented activity after the opening phase (Beach, 2019; Ekberg et al., 2024; Heritage & Clayman, 2010). It involves two related tasks: doctors gathering patients' concerns and patients describing their problems. Conversation Analysis (CA) research examines these activities by analyzing both the immediate interaction and the linguistic structures (such as grammatical choices and wording) that shape them, highlighting the intersection of social, institutional, and interaction orders.

2.1. Physicians' inviting problem presentation

Physicians often invite problem presentations (Robinson, 2006; Robinson & Heritage, 2006). Physicians' initial actions in soliciting problems, including their choice of question formats and wording, significantly affect the duration, quality, and structure of patients' problem presentations (Heritage & Robinson, 2006a). Research indicates that physicians' opening moves influence whether patients present new, follow-up, or routine concerns, as well as the length and internal organization of their problem presentations (Heritage & Clayman, 2010; Robinson, 2003; Robinson & Heritage, 2006). For instance, general inquiry questions (e.g., 'How can I help you today?') typically elicit longer responses (averaging 27 s), whereas confirmation-oriented questions yield shorter responses (16 s for gloss confirmation and 8 s for symptom confirmation). Additionally, physicians may incorporate relational and affective elements into their opening actions, building trust and encouraging patients to share sensitive yet relevant information for diagnosis (Robinson & Heritage, 2005). Studies suggest that these relational aspects correlate positively with patient satisfaction (Robinson & Heritage, 2006).

2.2. Patients' presenting problems

Patients' presentations of medically relevant concerns vary in linguistic and interactional formats, drawing on sociocultural and institutional resources. Regardless of how physicians initiate problem exploration, patients' initial units of presentation often set expectations for the structure and length of the subsequent discussion (Heritage & Clayman, 2010). Research shows that presentations often take the form of a narrative, allowing patients to describe their own experiences with the problem (Heritage & Clayman, 2010). Narratives also help patients present the complex issues that are difficult to put into words because of the low 'codeability' of such medical problems (Zimmerman, 1992). Patients' problem presentations include symptoms, past visits, emotional reactions, pain descriptions, and personal disclosures (Robinson & Heritage, 2006). Their lexicogrammatical choices predict the structure, duration, and content of their presentations. Brief presentations often involve simple declarative statements (e.g., 'I have X'), while elaborate presentations might feature narrative prefaces (e.g., 'Let me tell you what happened'). In more complex cases, patients may embed diagnostic suggestions or frame their symptoms as pointing toward specific conditions (Kallio et al., 2010; Stivers, 2002). These interactional choices shape how physicians respond, either through independent reasoning mobilized by direct, symptom-focused questions or by aligning with patients' implied diagnoses and recapitulating patient-provided information (Heritage & Clayman, 2010; Kallio et al., 2010).

2.3. Joint accomplishment of successful problem exploration

Effective problem presentation depends equally on the interactional and communicative competence of both doctors and patients. Missteps on either side can disrupt the flow of communication. Ideally, doctors adeptly initiate and guide the interaction while patients present their concerns clearly and efficiently, ensuring that medically relevant information is conveyed within the limited consultation time. However, what constitutes 'adequate' information is contextually negotiated and jointly accomplished (Heritage & Clayman, 2010). Robinson and Heritage (2005) highlight the 'current symptom' as a transition point from problem presentation to data gathering in acute primary care. This transition is often marked by present-tense grammatical constructions, signaling patients' readiness to yield the conversational floor to physicians. Misalignment in timing—when doctors intervene too early or late, or patients relinquish the floor prematurely or belatedly—can disrupt this transition, underscoring the delicate coordination required for effective problem exploration.

Robinson and Heritage (2005) provide interactional evidence for various practices, noting that the current symptom marks the completion of the problem presentation and that both the physician's and the patient's actions are centered on this turning point. Of the 302 problem presentations Robinson and Heritage examined, 25% were completed after one current symptom, and 53% were completed after two or more, suggesting the 'normativity' of such practices in interaction and the 'accountability' of the anomalous or 'deviant cases' (Heritage, 1984). Such an explanatory framework can help analysts understand how participants collaboratively determine what should be presented, how it should be conveyed, and what qualifies as a complete presentation (Robinson & Heritage, 2005).

2.4. DPI in secondary care

Doctor-patient interaction in secondary care has its own unique features. In outpatient secondary care, the nature of the disease, as determined by the type of medical specialty, significantly impacts the structure and trajectory of problem presentations (Beach, 2019). Patients who refer to a specialist might already have been diagnosed with an illness or have undergone diagnostic tests that facilitated the diagnosis. This influences the structure of the interaction. While secondary care shares a structure similar to primary care, the known nature of the diagnosis in some specialities would lead to a different type of interaction. For example, patients who are referred to a surgeon are either already diagnosed with a surgery-required disease (in the case of referral from primary care) or envision that they would undergo surgery (in the case of self-referrals). Relatedly, as illnesses treated in secondary care are often complex, multilayered, and advanced, their diagnosis relies on technology-aided evidence more than those treated in primary care. However, a gap remains in understanding how technology affects secondary care consultations, particularly when diagnostic imaging and laboratory results are more prominent. This study explores how problem presentation occurs in Persian-language interactions within secondary

Table 1
Distribution of the participants.

Participants	Male	Female	Total
Doctor	5	0	5
Patient	20	20	40
Companion	9	13	22
Total	34	33	67

care, explicitly analyzing how diagnostic evidence influences the interactional dynamics of problem presentation.

3. Method and context of the study

3.1. Data and participants

The data for this study come from a larger corpus that includes 150 audio-recorded outpatient consultation visits in Iran's secondary care, totaling 25 h of conversations among 10 specialist physicians (SPs), 150 patients, and 90 companions. The recordings were made in the SPs' private offices using their own phone recorders, in accordance with the ethical procedures of the relevant medical university in Iran and the funding institution of the research project (see acknowledgment). For this study, 40 medical consultation visits in the private sector, which included verbal problem presentation, were selected based on convenience sampling from the corpus and were transcribed according to the transcription conventions proposed by Jefferson (2004) for conversation analysis, with slight modifications to accommodate Persian.

The participants include five male SP; 3 internists (one of whom is subspecialized in pulmonology), one urologist, one general surgeon, and 40 patients, 22 of whom are accompanied by a companion (usually a family member). Table 1 represents an overview of the participants and their gender. Table 2 provides information about number and length of visits across specialists.

The visits represent first-time and follow-up illnesses, in which patients visit a new SP for the first time, either for a new problem or for a previous problem (including prior problems with the same SP). The overall visit duration of the selected visits varies from 3 to 15 min. Problem presentation in the current data involves a multi-turn activity that typically unfolds over several exchanges between doctors and patients, and at times, it even extends throughout the entire interaction. Iranian patients often revisit their problems in later consultation phases to reiterate and emphasize them, particularly once trust has developed between them and the doctor. The doctor's interactive behavior and responsiveness to the patient play a vital role in this process. Nevertheless, following Robinson and Heritage (2005), I examine the doctor's invitation and the initial presentation of the patient's problem until the doctor takes the next turn, either to commence the data-gathering activity or to redirect the patient's presentation.

The average duration of problem presentations before the doctor initiates data-gathering activity or redirects the problem presentation is 22.75 s. Given that all problem presentations in this study followed 'general inquiry questions' by doctors, this duration is slightly lower than the duration of the initial unit of problem presentation in the primary care (27s) reported in Robinson and Heritage's (2005) research (Heritage & Clayman, 2010). The shortest problem presentation lasted only 1.2 s and included explicit delivery of diagnosis (*prostate daram*: I have prostate). The lengthiest, however, lasted 105 s. In 27 visits, the patients presented a narrative and implicitly or explicitly offered a candidate diagnosis (avg. 30s). In 11 visits, patients presented 'only symptom' and 'only diagnosis' (avg. 10s), and 2 problem presentations involved only a request to examine test results.

3.2. Context of the data: Private outpatient secondary care in Iran

The study examines medical interactions in private outpatient secondary care, specifically focusing on doctor-patient interactions (hereafter DPI) in the private offices of Specialized Physicians (hereafter SP). The private sector in Iran provides 75% of outpatient medical services through private hospitals, clinics, and individual offices, and 15-20% of inpatient services (Barekat, 2025). The term "secondary" may be more appropriate in health policy contexts (e.g., the UK), where a stepwise procedure allows patients to access specialized care after primary care treatment and diagnosis, leading to referrals for further examination and treatment by primary healthcare providers (e.g., general practitioners). However, in many healthcare systems, including Iran, primary healthcare is not a prerequisite for accessing specialized care (cf. Ekberg et al., 2024). In Iran, private specialists (i.e., specialists with private offices) are accessible to patients without requiring a referral from a general practitioner or any other primary healthcare provider (see Ekberg et al., 2024 for a similar medical system). Patients often reach SP offices through self-referral (cf. Beach, 2019), recommendations (or referrals) from other SPs, or even family and friends, in addition to referrals from primary health providers. Many patients tend to bypass GP visits and directly consult the SP of their choice. It is common for patients to switch SPs if they are dissatisfied with treatments or the SP's behavior. This sometimes necessitates patients from smaller towns and cities to travel to larger, more prosperous cities to see their SPs.

In Iranian medical education, there is no systematic training on effective communication with patients. As research on Iranian medical ethics indicates (e.g., Sherafat et al., 2023), doctors are advised in ethics courses to treat patients with kindness and respect; these lessons often lack specificity about what constitutes respectful behavior. Furthermore, there are no established educational protocols addressing the structure of doctor-patient conversations or any oversight of doctors' linguistic behavior during patient interactions. As a result, doctors have significant freedom in how they communicate with and behave toward patients (Attari et al., 2010). Nevertheless, many doctors intuitively recognize the importance of effective communication—both for ethical reasons and for strategic, consumer-driven motivations (cf. Sherafat et al., 2023). In the private healthcare sector, doctor-patient interactions often resemble service encounters, in which principles of consumer satisfaction are at play. Doctors are expected not only to provide medical care but also to attract and retain patients to ensure profitability. Despite the shortage of specialized physicians, competition remains high, particularly in larger cities. However, this consumerist perspective should not overshadow many doctors' genuine ethical commitment.

4. Conversation analysis and discussion: Internal structure, current symptoms and the relevance of diagnostic imaging test results in the design of verbal problem presentations

This section presents a detailed conversation analysis of selected excerpts from the data that reveal the internal structure of problem exploration in Persian DPI, particularly with regard to the relevance of current symptoms and the impact of diagnostic imaging tests on the trajectory of talk. To understand the data, readers are presented with three aspects of the Persian language grammar, which are relevant to the analyses: 1) Persian is a pro-drop language, and the subject of the sentence is not apparent until the end of the sentence, where a person particle suffixes to the root of the verb, as in *raft-am dandunpezeshki*: (went-I dentist: I went to the dentist). 2) Formal Persian follows a Subject-Object-Verb (SOV) sentence structure pattern, but scrambling is also possible; that is, in spoken conversations or in poetic and rhetorical genres such as political sermons, a Persian clause can begin with a verb or an object. 3) Persian is an honorific-rich language, providing a variety of grammatical and lexical resources to its speakers to practice deference by elevating their addressee and lowering self (Izadi, 2022b, 2025).

4.1. Doctors' orientation to verbal presentation prior to diagnostic test evaluation

In this section, I explore situations in which patients quickly present their test results, but doctors do not accept them. The interactional evidence for this mismatch between the patients' and the doctors' orientation about the proper order for evaluating test results is the doctors' focus on delaying and their increased solicitation of verbal presentation. The two excerpts shown below feature two SPs: a surgeon (Excerpt 1) and a urologist (Excerpt 2).

4.1.1. Excerpt 1: Doctor's postponing the examination of the documents

This interaction takes place between a female patient and a male surgeon in his private office. The entire visit lasts 12:34 min, but the presentation of the problem only takes 73 s. The excerpt shows the interaction after the greeting, which is the opening phase of the visit. During the problem presentation, the patient implicitly requests twice to give the floor to the doctor, but the doctor declines and encourages the patient to continue. The patient presents the problem, while the companion remains silent.

Data code: S103
Male surgeon with female patient and female companion.

01	DOC	xob xãhar-am beh-em befarmã-yeed cheto shod-e, ok my sister to-me command-2P how has become-3S **ok my sister please tell me what has happened**
02		(0.3)
03		badan man inã ro negã mikonam hatman. later I these OM look do-1S certainly **then I will definitely look into these**
04	PAT	ba-. yea- **yeah**
05		(1.2)
06	PAT	ãy doctor ma:n, Mr doctor I **Mr doctor I**
07		(0.5)
08		dandunpezeshki raft-am do mãh-e pi:sh, dentist went-1SG two month-EZ ago **I went to the dentist two months ago**
09	DOC	ãhã, umm **uhm**
10		(1.1)
11	PAT	ba´d az ru-ye lop-a:m, then over cheek-my **then over my cheek**
12		ye: chizi darumad hãlate ãbse. a thing appeared like abscess **something appeared like an abscess**
13	DOC	ãhã. uhum **uhum**
14		(0.3)
15	PAT	dãxele gardan-am ham darumad az injã omad. inside neck-my too appeared from here came **inside my neck too it came from here**
16		(0.5)
17	DOC	>doros´e<.

		right **right**
18	PAT	omad chasbid be in. came stuck to this **and it stuck to this**
19		(0.8)
20		ba´d e: raft-am ((city)), then went-1S **then I went to ((city))**
21		((1 line omitted))
22		(0.8)
23	PAT	ba´d goft-an ke bãyad in nemuneh bardãri be-sh-e.= then said-3P must this sample SUB-be-3S **then they said this must be sampled**
24	DOC	=°>dor´s´eh<°. right **right**
25		(0.2)
26	PAT	to shahr-e xod-emun raft-a:m, in city-EZ self-us went-1S **in my hometown I went**
27		panj tã sorang nemuneh bardãri kardan o, five syringe sample taking did and **they sampled five syringes and**
28		ferestãd-an barã pãtology. sent-3P for pathology **sent them for pathology**
29		(0.3)
30	DOC	Ba:le, yes **okay**
31	PAT	javãb-esh omad-e::, result-its come-has **the result has come**
32		((Rustling and murmuring sound 6.0))
33	DOC	chashm chash negãh mikon-am. eye eye look do-1S **sure sure I will look into them**
34	PAT	((UNDECIPHERABLE)) in ´am hast. ((UNDECIPHERABLE)) this too is **((UNDECIPHERABLE)) this one too**

35 (9.0)

36 PAT ↓dige goft-an ke::-,
then said-3S that
then they said that

37 ye nemunebardãri ferestãd-im,
a sampling sent-2P
they sent the sampling

38 injã barã-ye shomã fek kon-am yã ye doctor-e dige:,
here for-EZ you think do-1S or one doctor other
here I think or to another doctor

39 goft-e bud-an ke,
said had-3P that
they said

40 kãmel nabud-e ne- un nemunebardãri.
complete not been that sampling
the sampling had not been complete

41 (4.5)

42 PAT hãlã ham har tor shomã salãh midun-id.
now too every kind you expediency know-2P
and now whatever you think is best

43 (2.8)

44 PAT alãn ´am dobãreh por shod-e.
now too again full become
now it has filled up again

45 meqdãri sefttar shod-e=.
a bit stiffer become
and become stiffer

46 DOC =↑BALE man hatman moãyeneh mikon-am.
yes I definitely examine
sure I will definitely examine you

47 >bã ej´ze shomã<=.
with permission you
with your permission

48 PAT =∘xãhesh mikonam∘. ((clears throat))
request do-1SG
no problem

49 DOC ↑XOB tu xãnevadeh sãbeqe-ye kasi ke tiroeede-sh-o…
okay in family history someone that thyroid-3S-OM…
ok do you have someone in the family with thyroid

Table 2
Number of visits (N), length of problem presentations (PP) and Min.-Maximum length of problem presentation (PPmin.-max) across specialists.

SPs	N of visits/ patients	PP avg. (in secs)	PPmin.-max (in secs)
Internist-Pulmonologist	4	23	5-48
Internist 1	3	9.3	3-20
Internist 2	3	9.6	5-17
Urologist	19	15.8	1-43
General Surgeon	11	41.9	5-120
Total	40	Avg. 22.75	1-120

After the greeting is completed and following a few seconds of pause (11.8: data not shown), the doctor solicits the problem by an address term ("*xahar-am*: my sister": *line 1*) that frames the encounter as rapport-based and collaborative and a general inquiry (Heritage & Robinson, 2006a). The solicitation is syntactically formatted as imperative with the question embedded as a noun clause "*behem befarmā-yeen ke chetor shod-eh*" (please tell(pl) me what has happened: *line 1*). Generally, such an open question lays the ground for the patient to display an elaborate problem presentation (Heritage & Clayman, 2010; Heritage & Robinson, 2006a). The honorific term *befarmāy-eed* (Izadi, 2022a), along with the nominalized question, conflates the doctor's seeking information from the patient and offering help, showing the doctor's orientation to medical interaction as a site for service encounter (cf: Robinson, 2001).

The doctor's question is followed by "*ba'd man inā ro negāh mikonam* (I'll look into these later: *line 3*)", suggesting the patient's embodied action of placing the documents on the doctor's table. Also, the turn construction unit (TCU) provides evidence for the doctor's interpreting of the patient's action as a request to examine the documents. The unit is interpretable as a postponement of the patient's earlier request to examine the test results (cf. Arundale, 2020, for projecting and interpreting of actions). So, the doctor's turn here inhabits an additional action of verbally responding to an implicit non-verbal request, which is approved by the patient in her soft-produced, overlapping *ba-*:yea (*line 4*).

The patient starts her turn (*line 6*), after a short pause (*line 5*), with an initial unit comprising an address term (*"āy doctor":* Mr doctor), pronominal self-reference (*"man"*: I), and a short pause (*line 7*), projecting that the presentation is going to be very long and multi-unit (Heritage & Clayman, 2010). Prefatory address terms (address terms occurring at turn beginnings), when recipiency is already settled, are linguistic practices that (among other things) show the speakers have framed their action independently of the prior action (Clayman, 2013). The patient goes on to present the problem in a stepwise manner, starting with a historicized narrative with reference to time (two months ago) and place (dentistry) (*line 8*), implicitly relating her problem with her last visit to the dentist.[1] She gradually builds up the problem by providing details (*lines 11-28*). She describes her problem as a "thing" like an abscess (*line 12*) that appeared on her cheek and then on her neck, framing it as a 'gloss for concrete symptom' (Heritage & Clayman, 2010; Heritage & Robinson, 2006a), and as an analogy that together depicts a moderate level of granularity (Schegloff, 2000). She then recounts her previous medical actions, including biopsies and pathology tests. Throughout, the doctor uses comma-intoned minimal responses ("*āhā*: *uhum*", "*bale*: okay"), which signal active listening and encourage continuation, an orientation to the inadequacy of the presentation (Heritage & Robinson, 2006a; Robinson & Heritage, 2005).

The recount leads to "*javābesh omade:* the result has come" (*line 31*), followed by her embodied search for the documents, signaling a temporal shift from past to present and from narrative to the 'here and now' of the consultation (Heritage & Clayman, 2010). Therefore, interactionally, it is a possible completion point for problem presentation that invites a shift to the next action. The doctor's upgraded acceptance in line 33, "*chashm chash negāh [mikon-am*: sure, sure, I'll just look at them", retroactively provides interactional evidence for the patient's delivery of the documents (as further displayed by her increment: *"in-'am hast"*: this one too: *line 34*) and his understanding of it as an implicit request to examine them. The upgrade also resonates with his postponement of the document examination requested by the patient at the beginning of the consultation. The 9-s pause (*line 35*) signals a shift to the examination of the document.

After 9 s of silence created by the doctor's reading the test results, the patient uses the opportunity to present the residue of the problem (in a lower voice), starting with the addition discourse marker "*dige*", also used to resume talk. This unit ends with the 'exit device' (Heritage & Clayman, 2010) "*halā ham har tor shomā salāh midunid*: and now whatever you think is best" (*line 42*), completely deferring to the doctor's (medical) epistemic authority. However, the doctor is not yet ready to take up the floor (as evident in the 2.8 pause in *line 43*), as he is still reading the results, giving more space to the patient to present a stronger current symptom ("*alān 'am dobāreh por shod-e meqdāri sefttar shod-e:* and now it's been filled up again: it's become stiffer": *line 44*), increasing the legitimacy of her visit by adding an increment that invites physical examination (Heritage & Robinson, 2006b). Finally, the doctor accepts the request for examination but again postpones it: His "*man hatman moāyeneh mikon-am > bā ej'ze shomā<:* I will definitely examine you, with your permission (*lines 46-47*)", latches to the patient's response to his polite token (with your permission): you are welcome (*line 47*). The transition to data gathering is signaled by the doctor's shift-implicative (Beach, 1993) "XOB" (okay), which displays his orientation to the completeness of the prior problem presentation (*line 49*).

This interaction shows how the doctor manages competing courses of action—soliciting a verbal problem presentation while simultaneously orienting to the patient's implicit request to have her documents examined. His use of honorific address terms, polite imperatives, and upgraded acceptances frames the encounter as service-oriented and collaborative, yet his repeated postponements of document review also constrain the patient to proceed with a multi-unit narrative. The patient responds by constructing a stepwise, historically anchored account and by supplying additional symptoms until she reaches a possible completion point marked by an exit device. Throughout, the doctor's minimal responses and pauses display active listening while maintaining control over the timing of transitions. The excerpt highlights how the interactional management of document examination—whether postponed or taken up—shapes the trajectory of the problem presentation and reinforces the doctor's epistemic and deontic authority in deciding when the shift to diagnostic action occurs.

4.1.2. Excerpt 2: Relying solely on test results: an incomplete, inappropriate problem presentation

Unlike in the previous excerpt, this excerpt presents an incomplete case. Past research shows that when patients fail to provide a complete presentation, they require more effort from the doctors because they have to do all the diagnostic work independently (Ijäs-Kallio et al., 2011). Like the surgeon in the previous excerpt, the urologist in the following excerpt also orients to solicit the verbal presentation before the document examination. The entire visit lasts 6:18 min, with the problem presentation taking 30 s. The patient is diagnosed with kidney cysts and receives medication for it. Both the patient and his companion (his spouse) are elderly and illiterate, and they present the problem collaboratively, quickly after the greeting.

[1] The doctor displays such understanding, as evident in his response later in interaction (data not shown: cf: Ijäs-Kallio et al., 2010).

Data code: A408
male urologist, male patient, and female companion.

01	DOC	chi shod-e aziz-a:m? what become dear-my **what is it my dear**
02	PAT	chiz-e: ãzmãyesh ham dãr-am. thing-is test too have-1S **I also have the test**
03		goft ãzmãyesh ´am nagã kon-e ay doctor. said test too look do-3S Mr doctor **he said Mr doctor also check the test**
04	DOC	xo:b, okay **okay**
05		(0.5)
06	DOC	hãlã ãzmãyesh-et ´am mibin-am, now test-your too see-1S **I will also see your test**
07		xodet-am bego chi shod-e nãrâhati-t chi-e? yourself tell what happened discomfort what-is **tell me what has happened what is bothering you**
08	PAT	=wollãh e: nãrahati nadãsht-om raft-. DM problem not had-1S went-1S **well I did not have any problem I went**
09	COM	nadasht raft anjãm dãd chi. did not have went did what **he went and did what**
10	PAT	hamachi anjãm dãd-om. everything did-1S **I did everything**
11	COM	raft e: (0.8) sonogrãfi nevesht barã-sh, went sonography wrote for-him **they wrote a sonography for him**
12		goft charbi kabed inã dãr-eh. said fat liver these has-3S **he said he has fatty liver and stuff**
13	PAT	=in mãl-e eee ((Lab name)). this belongs-EZ **this test belongs to ((Lab name))**
14	PAT	ãzmãyesh. test **test**
15	COM	dige eee (0.5) bord-esh barã ((doc name)), then took-him for **he took it to ((doc name))**
16	COM	((doc name)). **((doc name))**

17	PAT	dobãreh raft-om chiz gereft-om, again went-1S thing got-1S **again I went and got something**
18	COM	goft dobãreh bãyad ber-i chiz anjãm bed-i. said again must go-2S thing do-2S **he said you must do the thing again**
19		sonogrãfi anjãm bedi. sonography do-2S **do the sonography**
20	DOC	bebinam sonogrãfi ro. see-1S sonography OM **let me see the sonography**
21	DOC	edrãr rãhat mikoni bãbã? urination easy do-2S dad **do you urinate comfortably dad**

The doctor starts with a general inquiry question "*chi shod-e*: what's up" (*line 1*), followed by an endearment, "*azizam*: my dear" (*line 1*), a solidarity-indexing address term common in the Persian culture. Although the general inquiry question normatively lays the ground for an elaborate verbal presentation, the patient's orientation to comply fully with the question's projected course of action (Raymond, 2003) is limited, as he displays difficulty in selecting the right word to describe his condition. He uses the vague term *chiz* (stuff or thing) and shifts the focus to his test results, saying, "*ãzmãyesh ham dãram:* I have tests too" (*line 2*), and reporting the previous doctor's recommendation to check the test results "*goft- ãzmãyesham negãh kon-e ãy doctor:* (He) said Mr. doctor look at the test" (*line 3*), as an alternative to verbal presentation. Orienting to the inadequacy of this response, in lines 6 and 7, the doctor reformulates and reinforces the question, while promising to examine the documents later, urging the patient to articulate his symptoms verbally before turning to the test results ("*hãlã ãzmãyesh-et 'am mibin-am xodet-am bego chi shod-e:? nãrãhati-t chi-e?* I'll look at your test too, but first, tell me yourself what's wrong. What's bothering you?"). The doctor maintains an affiliative tone, using singular pronouns and verb forms to foster a sense of familiarity. At the same time, his upgrade in specificity ("*nãrãhati-t chi-e?* – What's bothering you?") seeks to constrain the patient's response, nudging him toward a symptom-based answer, and guiding him more effectively—an approach that aligns with the patient's limited literacy and indicative of his voluntary assistance, which shows his orientation to the patient's recruitment of help (Kendrick & Drew, 2016).

The patient picks up on the word *nãrãhati* (discomfort) and responds in a dispreferred way, hedging with the pragmatic marker "*wollã*"[2] ("*wollã nãrãhati nadãsht-om raft-om*: Well, I didn't have any discomfort, I went": *line 8*). He frames his issue in a past-oriented account, paradoxically implying the presence of a current problem while signaling epistemic uncertainty. This response reinforces his initial orientation to request that the doctor review the test results rather than verbally describe his symptoms. His difficulty in articulating a clear and comprehensive problem becomes more apparent as he struggles to construct a narrative. When he begins with "*raft-om:* I went … ", his wife interjects to complete his thought (a practice of collaborative storytelling: Mandelbaum, 2012), saying "*raft anjãm dãd chi:* He went and did the stuff" (*line 9*), overlapping with the patient's own confirmation, " *hamechi anjãm dadom*: I did everything" (*line 10*). Both utterances remain vague, lacking specificity or any direct mention of symptoms until the companion recounts the previous doctor's assessment (third--party epistemic access), shifting the epistemic authority further towards medical documentation ("*goft charbi kabed inã dar-e:* he said he had fatty liver": *line 12)* (Heritage & Raymond, 2005). Finally, the doctor requests the sonography results (*line 20*) and goes on with history-taking, symptom-related questions, along with the examination of the sonography results (*line 21*).

This interaction shows how the doctor works to secure a verbally delivered problem presentation in the face of the patient's difficulty articulating symptoms and reliance on test results. The doctor's incremental reformulations, upgrades in question specificity, and affiliative stance collectively function to guide the patient toward a symptom-based account, while managing the patient's limited lexical resources and reliance on documentation. The patient's vague formulations, hedging, and dependence on his companion for help display his epistemic uncertainty and limited ability to construct a coherent narrative, further shifting epistemic authority to medical records and prior clinicians. Ultimately, the doctor's persistence in eliciting verbal symptoms, followed by his turn to the sonography results and targeted questions, reflects the institutional preference for clinician-led, symptom-focused accounts in organizing the diagnostic pathway.

4.2. Doctors' orientation to the diagnostic test leading to two interactional troubles

The following two excerpts illustrate SPs orientation to examine the diagnostic tests before the patients' narratives and verbal presentations are complete. In excerpt 3, the companion, who speaks for the patient, delays the submission of the CT scan results, leading to the doctor's sudden command to hand them in when noticed. In excerpt 4, however, the patient presents the test results before verbally presenting the problem, creating a situation where the doctor does multi-tasking

[2] It is an Arabic loan word that literally means swear to God, but in Persian, it has several pragmatic functions in addition to its original meaning: In turn beginnings like here, it is a marker of disalignment and dispreference. A similar particle in English is 'well' (cf. Heritage, 2015).

(researcher's observation).[3] However, multitasking creates interactional trouble in the flow of the transition to data gathering.

4.2.1. Excerpt 3: Doctor rushing to CT results, companion has to relinquish the floor

This interaction involves a male pulmonologist and a male companion who has brought his father to the appointment. The patient is diagnosed with COVID-19 during the same visit. The entire interaction lasts 11 min and 8 s, with the problem presentation taking 26 s. The problem is presented by the patient's son, the companion, after two sequences of greetings.

Data code: A103

Male Internist Pulmonologist, male Patient (old), male Companion.

01	COM	ãy doctor ãqã:-m Mr doctor father-my **Mr doctor my father**
02		(0.5)
03		ruzãy qabli mãh ramazun ruzeh gere:ft- days before month Ramadhan fast took-3SG **He fasted before Ramadhan**
04		(1.0)
05	DOC	ruzeh gereft ↑xo:b fast took-3SG okay **He fasted okay**
06		(0.7)
07	COM	zamãni ke ruzeh gere:ft- time that fast took-3SG **Since he fasted**
08		((lines omitted))
09		(0.3)
10		ehsãs-e e: xastegi mikon-eh feel-EZ fatigue do-3SG **He has been feeling fatigued**
11	COM	(0.5)
12		yani tamã:m-e badan-esh kesel-e means whole-EZ body-his tired-is **His whole body is tired**
13	COM	(0.5)
14		bihãl-e lethargic-is **He is lethargic**
15		(0.5)
16		↑BORD-im-esh docto:r took-we-him doctor **We took him to the doctor**
17	COM	((rustling sound)) **((rustling sound))**
18		(0.7)
19		↓alãn-am sarmã xord-eh now-too cold ate-3SG **And now he has caught a cold**
20		((lines omitted))
21		(0.5)
22		↑BORD-im-esh bimãresta:n took-we-him hospital **We took him to the hospital**
23		doctorã-y motxases chan´ bãr bord-im-e:sh

[3] Although the data are not video-recorded to show the participants' embodied actions, the researcher's own observations are used to claim the doctor's multitasking.

doctors-EZ specialized few time took-we-him
We visited a few specialized doctors

24 ((lines omitted))

25 COM bord-im-esh ke:
took-we-him that
26 **We took him to**

27 (0.2)

28 axe-sh in chizã gereft-im aze:-sh,
image-his these things took-1PL from-him
get some picture stuff done

29 goft-an [ke:-,
said-3PL that
They said that

30 DOC [↑CT SCAN kard-in?
CT scan did-2PL
Did you do a CT scan

31 COM ãreh=.
yes
Yes

32 DOC =BE-bin-am.
SUB-look-1SG
Let me see

33 COM ria-sh ofunat [dãr-eh-.
lung-his infection has-3SG
His lung has an infection

34 DOC [bezãr be-bin-am.
let SUB-look-1SG
Let me see

35 COM >aziz-am-i<.
dear-my-2SG
You are my dear ((thank you))

Again, the turn beginnings address term (*line 1*), third person nominal reference to the patient (*"ãqãm*: my father": *line 1*), and a short pause (*line 2*) project a lengthy and multi-unit presentation that will gradually progress. The address term also projects some independence of action beyond its normative function as attention-getting (Clayman, 2013). The companion formulates the problem in a historicized narrative (*"ãqãm mãh ramazun ruze gereft*: my father fasted in Ramadhan month": *lines 1-3*). This is prompted to continue by the doctor's understanding check (repetition of the last TCU), followed by a comma-intoned *"xo: b"* (*line 5*), suggesting he is waiting for more diagnostically relevant symptoms. The companion expands on the problem by providing the first symptom, feeling fatigued (*line 10*), reformulated as lethargic (*line 14*), which he implicitly relates to his father's fasting (since he fasted: *line 7*). He then moves to the next presentation unit, which is recounting a past visit. However, he abandons it to add an increment to the symptom earlier provided: *"alãn 'am sarmã xord-e*: and now he has a cold" (*line 19)*. He introduces cold as an additional symptom indexed in the word *"ham"* (too). Although the companion's turn marks a transition from past to present and the presentation of a secondary symptom, the doctor does not transition at this point. This could be due to several reasons: 1) colds lack 'doctorability' (Heritage & Robinson, 2006b), and patients are generally expected to manage colds without seeking medical attention. 2) The interaction occurs during the COVID-19 pandemic, which heightens the doctor's suspicion that a pulmonary infection might be the case, and hence, he should wait for further symptoms and 3) the companion had already started to recount their past visit to a doctor (*line 16*), which was abandoned, signaling that he will resume the recount later in the interaction as he does in lines 22-29.

While recounting their past visit, the companion uses a non-specific reference (*"ax-esh az in chizã*; picture this thing": *line 28*), indicating a lexical retrieval problem, which creates an opportunity for the doctor to repair and exert epistemic authority. The doctor forcefully interrupts with an other-initiated repair (have you done a CT scan? *line 30*), hurrying the interaction towards a medical examination by shifting epistemic authority from a lay narrative to a clinically relevant form. The doctor's imperative command in line 32, *"bezãr be-bin-am"* (let me see), signals a rapid shift from the problem to the examination of the document and bypasses the companion's presentation. His repetition of the command in line 34 (let me see) overlaps with the companion's diagnostic-implicative turn, which displays his orientation to the adequacy of the verbal presentation, although the companion orients to incompleteness of his presentation.

This interaction shows how the doctor's hurry to obtain biomedical data influences the organization of the problem presentation. The doctor withholds uptake on parts of the companion's multi-unit account but intervenes immediately when medically consequential opportunities arise—initiating repair, shifting to clinical questioning, and issuing directives that move the encounter toward examination. This intervention could also be justified due to the urgency of the COVID-19 situation and the need for medical symptom clarification, especially given the limited symptom description. Overall, the excerpt demonstrates how clinicians' data-driven interventions can redirect problem presentations, strengthening institutional imbalance in determining when and how transitions occur.

4.2.2. Excerpt 4: Patient delivering the test results in advance of verbal presentation and the doctor welcoming it

The following interaction involves a male internist and a young male patient accompanied by his mother. The interaction begins after the doctor welcomes the patient and his mother into his office, followed by a round of greetings. The entire visit lasts 8 min, with the initial problem presentation taking only 17 s before the doctor redirects the conversation. The patient states that the reason for the visit is his blood test showing elevated liver enzymes, but the doctor identifies obesity as the main cause. Before discussing the problem, the patient hands over his documents.

Data code A602
male internist, male patient (25 yo), female companion (P's mother).

1	PAT	xedmat-e shomã. ((handing the documents over)) service-EZ you-PL **here are the documents**
2	DOC	mersi motshaker. thanks thanks **thanks**
3	DOC	Moshkel-e-tun chi bud-e hãj xãnum problem-EZ-your what been haj madam **what has your problem been madam**
4	COM	↓in ãqã. this Mr **this gentleman**
5	PAT	vãllãh ãy doctor u:h (0.2) ↑panj sãl-e pi:sh, well Mr doctor five year-EZ ago **well Mr doctor five years ago**
6		(1.0)
7		be elat-e roãyat nakardan-e rejim-e qazãie o, because observe not-doing regime dietary **because of not observing a dietary regime and**
8		(0.5)
9		xordan-e charbihã-ye ziãd, eating fat-EZ a lot **eating too much fat**
10	PAT	daqiqan zir-e dandehã-m, exactly under ribs-my **exactly under my ribs**
11		(1.0)
12		zir-e pardeha-ye shekami, under membranes-EZ abdominal **under the abdominal membranes**
13		shoru be dard gereftan kard. start to pain taking did **I started feeling pain**
14	DOC	bale, okay **okay**
15	PAT	(0.5)
16		↑RAFT-am docto:r went-I doctor **I went to the doctor**
17		(0.2)
18		sono nevesht, sono wrote **he wrote a sonography**

19		ãzmãyesh-at neve[:sht,- test-your wrote **he wrote a test**
20	DOC	[↑UN moqe ke roayãt nakard-I, that time that observe not-did **when you did not observe the diet**
21		vazn-e-tun ziãd sho:d? weight-yourPL increased **did you put on weight**
22		((PAT responds))
23	PAT	ye azmãyesh barã-m nevesht, a test for-me wrote **he wrote a test for me**
24	DOC	xo:b, okay **okay**
25	PAT	ye check-up [da- a check-up do- **I had a check-up**
26	DOC	[↑Dard faqat zir-e dandehã-t bud? pain only under ribs-your was **did you feel pain only under your ribs**
27	PAT	dard DAQIQAN haminjã pain exactly here **the pain was exactly here**
28	DOC	ãhã ye dard-e noqte-i dãsht-i okay a pain-EZ point had-youSG **okay you had a sore point**
29	PAT	lahzei migereft. momentary took **it was a momentary pain**
30	DOC	uhum, uhum **uhum**
31	PAT	RAFT-am doctor ãzmãyesh dãd-am sono dãd-a:m, went-I doctor test gave-I sono gave-I **I went to the doctor I took a test and a sono**
32		((narrative continues))
33		chiz-i ke nãrãhat-am kard, thing-IND that concern-me did **what concerned me**
34		ãnzimã-ye kabed tu xun-am bud, enzymes liver in blood-my was **was the liver enzymes in my blood**
35		ke tãze (0.5) ijãd shod-e. that newly create been **which have just appeared**
36		alãn xedmat residim ke shomã dastur bed-in. now service arrived that you command give-PL **we are now here for your instruction**

Here, the patient submits the documents as soon as the greeting is over, using the conventional honorifics *"xedmat-e shoma"* (lit. at your service: *line 1*) and the doctor accepts them and thanks the patient (*"mersi motshakker*: thank you": *line 2*). The doctor then elicits the problem using an interrogative in the present perfect tense: What has your problem been? (*line 3*). The present perfect tense is more fitted to a problem in the past for which the patient has taken a laboratory test. The doctor first addresses his question to the patient's mother (annexing the address term *"haj xãnom:* haj[4] Madam" to the question), misidentified as the patient. Expectedly, this is repaired as the patient's companion (his mother) diverts her turn to the patient (*line 4*).

The patient, now properly addressed, initiates the problem presentation (*line 5*) with two opening units, which are interactional cues for a lengthy presentation (Heritage & Clayman, 2010): *"vãlla"* (well), *"ãy doctor"* (Mr. doctor) and historical narrative marker *"panj sãl-e pish"* (five years ago). He then contextualizes the problem by explaining past dietary habits (due to not observing a healthy diet and eating too much fatty food), orienting to self-accountability. He formulates his problem as the onset of pain (gloss symptom: Robinson & Heritage, 2005) and its localization (*"daqiqan zir-e dandehã-m zir-e pardeha-ye shekami*: exactly under my ribs: *line 10*, under my abdominal membrane": *line 12*). A soft transition could happen here as the patient refers to the start of the pain, although it is not yet fully developed into a current symptom. However, the doctor's comma-intoned continuer (Heritage & Robinson, 2006a) (*bale,*: ok: *line 14*) projects his orientation to the incompleteness of the problem presentation and the need for further symptom-related information. So, the patient continues with the next unit of his presentation, which is his past visit experience (we went to the doctor, and he wrote a test and sonography), uttered in comma intonation, suggesting the continuity of his narrative. However, the doctor cuts it off to shift from illness narrative to clinical reasoning with a biomedically framed question about his weight when he was not eating a healthy diet:*"↑UN moqe ke roayãt nakard-i vazn-e-tun ziãd sho:d*? Did you put on weight when you did not observe a healthy regimen?" (*line 20*) The doctor had a better opportunity for a transition after the patient had specified the pain and had finished his first unit (as indicated by falling intonation: *line 13*), but he did not take it. The doctor waits for one more unit and then abruptly takes control with a biomedical question, which is an instance of interruption.[5]

The patient displays orientation to the incompleteness of the problem presentation by resuming the narrative (*line 23*) he had abandoned in line 19 twice after responding to the doctor-led biomedically-focused question (*line 18*) and the collaborative confirmation of the localization of pain in lines 26-29. The patient finishes the narrative by saying that the pain had disappeared after some time due to exercise, but links it to another narrative that he quit exercising for a few years and recently had undergone a new test, but has observed the elevation of liver enzymes in the test results (*lines 33-35*); a biomedical finding that had brought him. Finally, the patient finishes the narrative with an 'exit device' (Heritage & Clayman, 2010) in line 36: *"alãn xedmat residim ke shomã dastur bed-in:* We are now here (hon) for your command."

Overall, the excerpt highlights how dual engagement in document inspection and talk (as observed by the researcher) can challenge the organization of problem presentation sequences in DPI, temporarily displacing the patient's telling and requiring additional work from the patient to secure the opportunity to complete it.

5. Conclusion

This study investigates how medical issues are presented in Iranian secondary care consultations. The analysis of interactions between specialized doctors and patients reveals how institutional talk evolves and what factors shape the internal structure of problem exploration. The study specifically highlights a dynamic interplay between current symptoms as a transition point and the introduction of diagnostic test results in secondary care consultations. Conversation analysis supports Robinson and Heritage's (2005) model, emphasizing that eliciting and presenting the problem is a collaborative activity where doctors and patients negotiate the shift from illness narratives to clinical reasoning. The moment when a current symptom becomes the focus marks a turning point, prompting the doctor to actively guide the consultation. The cases reinforce previous CA-informed research on doctor-patient interaction, showing that medical transitions are interactionally negotiated processes (Gill & Maynard, 2006; Heritage, 2011; Heritage & Clayman, 2010; Heritage & Robinson, 2006a), and that these processes sometimes do not proceed smoothly but involve interactional challenges such as pauses, disruptions, modifications, or even reversals of the conversation's trajectory.

The study also indicates that Iranian patients utilize narratives as an interactional and linguistic resource to present themselves and their medical issues. The tripartite elements—address terms, self-reference (including references to patients if a companion presents the problem), and a brief pause—offer interactional evidence supporting the projection of a relatively lengthy and detailed narrative. This method aligns with patients' interactional behaviors worldwide, as shown in previous research (cf. Heritage & Clayman, 2010). Patients' lay descriptions and subjective narratives provide a chronological account, offering a holistic perspective that considers lifestyle and past experiences, allowing them "to tell the story of their problem in their own words, in an order of their own choosing, incorporating elements of sensation and context, the reactions of others, the reasoning process by which some interpretations were discounted and others entertained, and by which revisions in perspective emerged" (Heritage & Clayman, 2010, p. 133).

However, the analyses in this study also show that secondary care has its own internal structure, while sharing many core interaction features with communication in primary care. First, the study reveals that doctors often open the presentation with questions that are grammatically formatted in the present perfect tense. The present perfect tense reflects the structural nature of secondary outpatient care visits, by assuming that the patient has lived with the problem for some time, and previous medical histories are central to understanding the patient's condition. The data further show the role of diagnostic test imaging in shaping interactions in secondary care consultations. Because patients commonly bring imaging or laboratory results, the organization of talk becomes sensitive to how and when these results are introduced. Diagnostic tests may complement or compete with verbally described symptoms, leading to moments of misalignment when doctors prioritize data inspection while patients pursue narrative completion, or vice versa. These misalignments manifest as delays, abrupt transitions, or temporary disruptions in progressivity, as seen across all four excerpts.

These findings contribute to the under-documented domain of Persian medical interaction and offer practical guidance for medical practitioners by illustrating how problem presentations are collaboratively constructed—and sometimes challenged—in secondary care settings. The study, however, does not claim generalizability of such observations to Iranian medical interactions. Also, some of the arguments in the paper would have been better supported by video-recorded data. Future research with broader participant diversity and additional specialties, as well as video-recorded data, will help extend these insights across linguistic and institutional contexts.

[4] Hãj (hãji) is a respectful address term used to address middle-aged and elderly men and women, alluding that they have accomplished the Haj pilgrimage. It can preface the gender titles of Sir/Mr and Mrs/Madam or be used independently.

[5] The observation of the researcher indicates that the doctor is multitasking here. The doctor engages selectively, which creates a lag in the conversational dynamic.

Declaration of competing interest

I declare no conflict of interest that could affect the preparation or publication of this paper.

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Glossary

[ ]: overlapped voice
=: latching
:: elongation of previous sound
-: cut off sentence or word
Word: stressed word in the sentence/clause
WORD: spoken in high pitch
?: rising intonation
,: continuing speech
.: falling intonation
↑: sudden rise in intonation
↓: marked fall in intonation
(1.0): length of pause in seconds
(.): pauses shorter than a second
° °: words between degree sign are soft words

< >: sottovoce
> <: faster voice
((.)): transcriber's description, undecipherable voice
@ @: between smile or laughter words
ā: Persian long a: vowel as in father
χ: voiceless velar uvular with scrape
q: uvular plosive
DM: discourse marker
OM: object marker
PL: plural
Sing: Singular
EZ: Ezafe marker

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