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Indice

Functions of Interrogative Structures in Advice Giving: A Case Study

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Activity types have been described as interactional events that impose constraints on the allowable contributions and on the inferential schemata used by participants to interpret the function of linguistic structures used. In this study, this theoretical framework is applied to the analysis of interrogative structures in clinical dialogues, highlighting their diverse functions in relation to the goal of the activity type, its structure and the roles of the participants. The results of the analysis contribute to ongoing research on questions in dialogues and on the study of communication in medical encounters.

Keywords: questions, activity types, discourse types, discourse analysis, doctor-patient interactions

1. *Introduction*[1]

In his description of activity types, Levinson emphasized in particular the importance of the structural properties of each speech event, which are "goal-determined" and generate the inferential schemata activated by participants within any activity[2]. It is these schemata which allow participants to interpret utterances in the correct way, i.e. according to what is expected within the activity in which they are involved. Indeed, activity types' main feature is that they impose constraints on what will count as an "allowable contribution"[3]; such constraints should be intended as constraints on the functions each utterance will be understood to have[4]. These notions imply that: 1. Language games, or conventional language uses within certain activities, tend to be determined by the goal of the activity and to be largely predictable based on what the participants understand to be the main function of the activity; 2. The constraints on allowable contributions within activity types are likely to be a crucial part of communicative competence, i.e. "the knowledge required to use language appropriately in cultural situations"[5].

[1] I thank Valentina Piunno and two anonymous reviewers for helpful comments and insights, which improved a previous version of the article.
[2] S.C. Levinson, *Activity types and language*, "Linguistics", 17, 1979, pp. 365-399, p. 369.
[3] *Ibid.*, p. 368.
[4] *Ibid.*, p. 395; P. Linell – D.P. Thunqvist, *Moving in and out of framings: Activity contexts in talks with young unemployed people within a training project*, "Journal of pragmatics", 35, 2003, 3, pp. 409-434, p. 412.
[5] S.C. Levinson, *Activity types and language*, p. 393.

One context of interaction that has not been frequently observed in terms of activity type is the clinical one. Clinical encounters have traditionally been described in a perspective that has emphasized power roles and the (potential) impact of communicative behaviors on clinical outcomes. In this perspective, mainstream research has aimed at identifying desirable behaviors that could be translated into 'communication skills' to use as training materials for clinicians[6].

Less attention has been paid to the characterization of such encounters as dialogical events, with the aim to describe the variety and specificity of the functions expressed by the linguistic structures employed by participants in the interaction. In this study, the notion of activity type is used as a heuristic tool to describe dialogical interactions in the clinical setting, with the specific objective of showing the connection between the goals and structural organization of such interactions and the functions of the interrogative structures involved in the process of providing expert advice to patients.

In the next paragraphs, clinical encounters will be described as activity types in which the main institutional goal is that of providing patients with expert advice. In the context of this description, attention is placed on the act of advice-giving and its complexity. Finally, a case study is presented, where interrogative structures have been analyzed in relation to the goal of advice giving in a small corpus of interactions in diabetes care.

2. *Clinical Encounters as Activity Types*

Clinical encounters can be considered as activity types of the more structured kind, i.e. where there is a certain degree of routinized behaviors. In this sense, they can be seen as belonging to a "communicative genre", which, in the words of Per Linell,

> involves particular verbal (and non-verbal) means for solving the tasks or functions associated with the genre. Furthermore, genres regularly involve participants in characteristic social roles and participant frameworks, and they co-determine possible topics and turn-taking systems. Communicative genres themselves vary in the degrees to which they are routinized and institutionally congealed. Since the use of genres is normally linked to clearly defined types of social situations, some of the most clear-cut genres are types of 'institutional discourse'[7].

Within a certain genre, an activity type can be described taking into account two important dimensions: topic trajectories and communicative projects[8]. Topic trajectories are produced by chains of 'thematic episodes' (or "islands of partially shared understanding"[9]), which are the expression of the dialogic work of striving for shared understanding through

[6] One notable example among many others, J. Silverman – S. Kurtz – J. Draper, *Skills for communicating with patients*, Radcliffe Medical Press, Oxon 1998.

[7] P. Linell, *Approaching dialogue: Talk, interaction and contexts in dialogical perspectives*, John Benjamins Publishing, Amsterdam/Philadelphia 1998, p. 240.

[8] *Ibidem.*

[9] *Ibid.*, p. 193.

the interaction. Topics emerge and are then discussed, defined, redefined, set aside and then re-topicalized, until clarity and understanding are achieved[10]. The notion of communicative projects instead refers to a structural property of activity types, whereby participants can be observed to 'work' (dialogically) towards the resolution of 'local' interactional problems that need to be solved in order to achieve the main goal or subordinate goals, e.g., finding agreement on a certain definition of an issue, decide on something that needs to be done, etc.

In the clinical context, projects are ideally cooperative and coordinated because the asymmetry of roles between experts and patients presupposes a complementary distribution of the workload; in other words, in order to achieve the institutional goal of the activity type, the contributions of both patients and experts, which differ qualitatively, are needed. This does not exclude that sometimes there might be a hierarchy of projects, so that smaller, more local, communicative projects need to be addressed before the higher-order project is tackled. For example, the participants might need to achieve agreement on a certain description of the disease before they can move on to the phase in which experts provide their recommendations.

Two important aspects have emerged so far that need to be developed further: what is the institutional goal of the clinical encounter, and what kind of contributions by experts and patients are allowed. These two aspects will be further discussed in the next section.

2.1 Institutional Goal and Participants' Roles in Clinical Encounters

Building on previous research, I propose to describe interactions in clinical contexts as tokens of an 'advice-seeking' activity type, which belongs to the communicative genre of lay-expert interactions[11]. The typical circumstance that produces an interaction between health care experts and non-experts is the occurrence of a health-related problem that non-experts are not able to solve by themselves. Thus, they seek expert advice[12]. The formulation of expert advice – advice-giving – is therefore the main institutional goal of this activity

[10] On the idea of 'trajectories' within dialogues, see also: C. Roberts – S. Sarangi, *Theme-oriented discourse analysis of medical encounters*, "Medical Education", 39, 2005, pp. 632–640; D. Duffin – S. Sarangi, *Shared decisions or decision shared? Interactional trajectories in Huntington's disease management clinics*, "Communication & Medicine", 14, 2018, 3, pp. 201-216.

[11] S. Bigi, *Communicating (with) care*, IOS Press, Amsterdam 2016; S. Bigi, *The role of argumentative practices within advice-seeking activity types. The case of the medical consultation*, "Rivista italiana di Filosofia del Linguaggio", 12, 2018, 1, pp. 42-52; S. Bigi, *The role of argumentative strategies in the construction of emergent common ground in a patient-centered approach to the medical encounter*, "Journal of Argumentation in Context", 7, 2018, 2, pp. 141-156; S. Bigi, *Le strutture interrogative nelle interazioni in contesto clinico*, Vita & Pensiero, Milano 2022.

[12] From now on, the term 'advice' is used to refer to an expert opinion in a broad sense: at the end of a medical encounter, patients may obtain prescriptions, which are formal acts, usually written on a special form detailing their content and modes of usage, but also simple instructions or recommendations, which may or may not be recorded in the electronic record and that have a different binding force from that of prescriptions. In the extreme cases of incurable diseases, 'breaking bad news' would also be considered as 'expert advice'. When the term 'advice' is used in this study, it refers to all of these acts performed by medical experts, aimed at achieving patients' wellbeing according to what the circumstances allow.

type, which determines the macro-structure of interactions falling within this description and the inferential schemata activated by participants (see par. 1). In its essential dynamics, advice is sought by patients and is provided by experts, but the ways in which advice-giving is realized (structurally and dialogically) are the most diverse and, again, crucially depend on the specific sub-goals determined by the characteristics of the various clinical specialties. An encounter in a clinic for assisted reproduction, for example, has specific goals that may differ from the ones in a diabetes care clinic, although in both cases the main aim of the encounter is to provide patients with expert advice[13].

Another level of complexity in the act of advice-giving depends on the kind of knowledge required in order to come up with the advice. This brings us to some considerations about the contributions allowed by experts and non-experts in clinical encounters.

The first consideration regards the nature of their contributions, which are not of the same kind (if they were, there would be no need for patients to seek expert opinions[14]). Experts contribute with expertise; patients contribute with experience[15]. Expertise presupposes specialized knowledge and implies the ability to recognize individual cases as instances of a 'type', i.e. to recognize a disease by observing certain symptoms, thus arriving at a diagnosis. It also implies being able to identify different possible solutions (therapeutic recommendations) to a problem (disease). Expertise however typically functions in relation to experience. Individuals do not accumulate knowledge for its own sake, but in order to be able to solve more and more problems, to understand phenomena, to provide ways of achieving wellbeing; expertise and experience need each other and this is true also in the clinical encounter, where experts would not be able to exercise their expertise if they did not have certain first-hand information from patients. Patterns of occurrence of phenomena and their statistical significance for certain groups within a population are useful if this knowledge can be used to solve the specific problems of single individuals, who might be deviant from the regularities observed through trials. Expertise means also being able to explain deviances within regular patterns and finding creative solutions.

In principle, the different nature of experts' and non-experts' contributions considered in relation to the goal of the activity type would predict that experts' and non-experts' "allowable contributions" (see par. 1) to the activity type should also be of a different kind. This means reconsidering the discussion on, for example, the participation of patients to decision making in medical encounters. Many scholars are currently putting under scrutiny the 'golden rule' of shared decision-making, which is considered almost a dogma in the

[13] S. Bigi, *Struttura e funzioni delle domande in ambito clinico. Un confronto tra il contesto della diabetologia e quello della procreazione medicalmente assistita*, paper presented at the "International Conference on Spoken Communication", 5-7 May 2021, Università del Piemonte Orientale, Vercelli (Italy).

[14] On this, see also R. Dingwall – A. Pilnick, *Shared decision making: doctors have expertise that patients want or need*, "British Medical Journal", 2020, p. 368.

[15] T. Spranz-Fogasy, *Verstehensdokumentation in der medizinischen Kommunikation: Fragen und Antworten im Arzt-Patient-Gespräch*, in *Verstehen in professionellen Handlungsfeldern*, A. Deppermann – U. Reitemeier – R. Schmitt – T. Spranz-Fogasy ed., Narr Verlag, Tübingen 2010, pp. 27-116, p. 32.

academia, but seems to find many obstacles in the clinical practice[16]. Perhaps it would be beneficial to reconsider it in the perspective of the goals, roles and allowable contributions determined by the activity type.

Based on these reflections on the nature of experts' and non-experts' contributions to the clinical encounters, another consideration is in order regarding their roles in the interaction. Clearly these roles are different and their difference is again determined by the goal of the activity type: by the act itself of coming to see an expert, non-experts are implicitly declaring their inability to cope, they are asking for direction and counseling. This objective circumstance makes the roles in the interaction unequal, which is what some scholars have observed analyzing the ways in which roles are played out by participants at the interactional level[17]. This difference between roles can be fundamentally seen as "asymmetrical division of labour in the pursuit of common goals"[18]. In this perspective, roles may be different in what they bring to the interaction, but they are of equal importance to the achievement of the goals of the interaction. The difficulties that are sometimes seen arising from the asymmetry of roles in clinical encounters surface at the dialogical level, but are probably caused by a misinterpretation of one's social role; or, to put it differently, by a misinterpretation of how a certain role should be played out within a certain language game (i.e., activity type).

2.2 Advice-Giving in Clinical Encounters

In the previous section, 'advice-giving' has been described as the institutional goal of clinical encounters understood as activity types, thus what determines their structure and the inferential schemata activated by participants in the interaction. A few further considerations may be useful regarding this goal, which is usually achieved through the combination of different discourse types[19].

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[16] Recent contributions to the ongoing discussion on the nature and possible operationalization of shared decision making: L.C. Kaldjian, *Concepts of health, ethics, and communication in shared decision making*, "Communication & Medicine", 14, 2017, 1, pp. 83-95; D. Duffin – S. Sarangi, *Shared decisions or decision shared?*; J. Gerwing – P. Gulbrandsen, *Contextualizing decisions: Stepping out of the SDM track*, "Patient Education and Counseling", 102, 2019, pp. 815-816; R. Dingwall – A. Pilnick, *Shared decision making: doctors have expertise that patients want or need*.

[17] J. Coupland – J.D. Robinson – N. Coupland, *Frame negotiation in doctor-elderly patient consultations*, "Discourse & Society", 5, 1994, 1, pp. 89-124; D.W. Maynard, *Language, interaction, and social problems*, "Social Problems", 35, 1998, 4, pp. 311-334; P. ten Have, *Talk and institution: a reconsideration of the "asymmetry" of doctor-patient interaction*, in *Talk and Social Structure: Studies in Ethnomethodology and Conversation Analysis*, D. Boden – D.H. Zimmerman ed., University of California Press, Berkeley 1991, pp. 138-163.

[18] P. Linell, *Approaching dialogue*, p. 258.

[19] Discourse types are defined as "ways of characterizing forms of talk (e.g., medical history taking, promotional talk, interrogations, troubles telling, etc.)", whereas activity types refer to the characterization of settings, S. Sarangi, *Activity types, discourse types and interactional hybridity: the case of genetic counseling*, in *Discourse and Social Life*, S. Sarangi – M. Coulthard ed., Pearson Education Ltd., Harlow 2000, pp. 1-27, pp. 1-2. On the notion of discourse type, see also J. Culpeper – R. Crawshaw – J. Harrison, *'Activity types' and 'discourse types': Mediating 'advice' in interactions between foreign language assistants and their supervisors in schools in France and England*, "Multilingua", 27, 2008, pp. 297-324.

The studies on advice-giving consistently describe it as a sequential speech activity, featuring the interplay of different discursive moves[20]. Locher characterizes advice-giving as a combination of assessing, judging and directing that regards a future action assumed to be positive for the advisee[21]. Regarding the acts of assessment and judgment involved in advice-giving, it has been considered that there may be a threatening or judgmental effect of advice-giving acts in a healthcare related context[22]. However, regarding this aspect, it is also important to recall the relevance of the wider speech event and of the norms of the practice in question for the interpretation of the force of advice-giving acts: individuals are likely to enter the dialogic activity with certain presupposed knowledge regarding who should provide the advice, how they should do it and about which topics. Such presupposed knowledge triggers the specific expectations interlocutors have when entering an advice-seeking activity type, which will impact on the way single speech acts are interpreted. It is likely that within an advice-seeking activity type individuals will interpret speech acts as advice even when they were not intended as such, and that they will not interpret advice as threatening for them[23]. The interpretation of an advice-giving speech act may impact also on the conversational outcomes of the exchange: it has been shown that mitigating an advice-giving speech act is not really necessary in cases where the advice had been solicited in the first place[24].

There are a number of important factors that should be taken into account when studying advice: practice (speech activity or practice); ideologies and culture (cultural contexts); hierarchical differences and role of expertise (relational work); solicited versus unsolicited advice; fuzziness of the concept (i.e., interlocutors can construe utterances as advice even without clear markers that signal their function. In the most dubious cases, the way the other party responds to an apparent advice can provide hints as to how the utterance was interpreted); advice-giving in different kinds of discourse (not only institutional, but also every-day, non-institutional and peer-to-peer interactions)[25].

In the clinical setting, the authority and reliability of expert advice usually derive from its connection to the structure of clinical reasoning, which proceeds by the identification of a disease, the explanation of symptoms, predictions about how the disease might evolve,

[20] M. Locher, *Advice Online: Advice-giving in an American Internet health column*, John Benjamins Publishing, Amsterdam 2006; I. Riccioni – R. Bongelli – A. Zuczkowski, *Mitigation and epistemic positions in troubles talk: The giving advice activity in close interpersonal relationships. Some examples from Italian*, "Language & Communication", 39, 2014, pp. 51-72.

[21] M. Locher, *Advice Online*.

[22] J. Heritage – S. Sefi, *Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers*, in *Talk at Work: Interaction in Institutional Settings*, P. Drew – J. Heritage ed., Cambridge University Press, Cambridge 1992, pp. 359-417.

[23] M. Locher – H. Limberg, *Introduction to advice in discourse*, in *Advice in Discourse*, H. Limberg – M. Locher ed., John Benjamins Publishing Amsterdam 2012, pp. 1-27, p. 5.

[24] I. Riccioni – R. Bongelli – A. Zuczkowski, *Mitigation and epistemic positions in troubles talk*.

[25] M. Locher – H. Limberg, *Introduction to advice in discourse*.

and efforts to modify the development of the disease[26]. These fundamental steps for the clinical practice reflect the dynamic movement from individual case to general rules and phenomena, and back again, which is the core ability of an expert (see par. 2.1). In other words, having observed a series of symptoms, experts consider them in the light of their general knowledge about a certain condition and derive from this consideration indications for action in view of healing or management of a disease.

Expert advice in the clinical setting, therefore, is not the same as moral advice, because the processes of assessing, judging and directing it involves are not grounded in moral principles, but in evidence that is interpreted in the light of specialized knowledge. This means that this kind of advice generates norms that refer to necessary conditions and the 'duties' that are implied by these norms should be observed not because there is a risk of being sanctioned, but because it is wise to do so[27]. Expert advice in the clinical settings, in other words, corresponds to detailing the conditions under which it might be possible to achieve patients' wellbeing[28].

In order to achieve the goal of 'giving expert advice', participants in the interaction need to cooperate so that experts will be able to collect all the relevant data they need, and patients will be able to receive the advice they were seeking. This cooperative work can be achieved through the combination of different strategies. This study is particularly concerned with how interrogative structures can be used as part of this effort.

3. *A Case Study from Diabetes Care*

In order to show how the goals and structural organization of the activity type may impact on the interpretation of the linguistic structures involved in the process of providing expert advice to patients, in this section a case study is proposed, based on a set of transcripts from a diabetes care setting.

Diabetes is a chronic condition caused by a metabolic disorder that impairs the processing of glucose in the blood[29]. If not treated, it can lead to serious complications and premature death. Treatments do exist and the disease can be managed also by adopting

[26] G. Federspil – P. Maffei – R. Vettor, *Lineamenti di Metodologia Clinica*, in *Metodologia medica e chirurgica*, S. De Franciscis – R. Marfella – F. Perticone – A. Sciacqua – R. Vettor ed., Idelson Gnocchi 1908, Napoli 2021, pp. 23-36.

[27] M.E. Conte, *Epistemico, deontico, anankastico*, in *From pragmatics to syntax. Modality in second language acquisition*, A. Giacalone Ramat – G. Crocco Galèas ed., Narr Verlag, Tübingen 1995, pp. 3-9; M. Carmello, *Alcune considerazioni pragmatiche su "dovere" in italiano: usi deontici e anankastici*, "L'Analisi Linguistica e Letteraria", 16, 2008, 1, pp. 229-235; L. Mori, *La distribuzione dei verbi modali in testi legislativi europei e italiani. Uno studio corpus-based sulla variazione intralinguistica di* dovere *e* potere, "Annali del Dipartimento di Studi Letterari, Linguistici e Comparati. Sezione Linguistica", 9, 2020, pp. 153-175.

[28] At this point, a reflection on uncertainty in clinical decision making in relation to the binding force of clinical advice would be appropriate, but it falls outside the scope of this discussion and it must be postponed to future papers.

[29] For more detailed information about diabetes, https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death (last accessed 7 June 2022).

healthy lifestyles; this, however, does imply that patients need to get actively involved in their own care. For these reasons, diabetes care is a particularly interesting context in which to observe interactions between experts and non-experts, given the particularly relevant role that effective communication can have in supporting patients' motivation and therapeutic adherence.

3.1 Materials and Methods

The analysis has been conducted on a small set of data taken from a corpus of transcripts of 53 video-recordings of encounters between health care experts and persons with diabetes. The corpus was collected in the period 2012-2014 at a diabetes outpatient clinic at the outskirts of Milano (Italy)[30]. All the health care experts in service at the clinic participated in the study (3 medical doctors, 2 specialized nurses, 1 dietician; all the experts were women), in addition to 20 patients (10 men, 10 women; age range: 60-90 years old; all patients were affected by Diabetes Mellitus Type 2). The data collection went on for 21 months and yielded 60 video-recordings for a total of 1800 minutes of recorded material, which was then transcribed. All the interactions are in Italian.

For this study, a random selection (n=7) of interactions with the diabetologists was compared with a random selection (n=7) of interactions with the nurses, observing in particular the functions of interrogative structures in the two groups, when used by experts and by patients.

Each consultation was analyzed first by identifying thematic episodes; within each episode, the interrogative structures were identified and their functions described in relation to their position in the turn sequence and in the dialogue. The analysis is qualitative and has been conducted manually.

In the next section, we briefly present the main characteristics of interrogative structures and the rationale for analyzing them in relation to advice giving.

3.2 Interrogative Structures and Questions

Between interrogative structures and questions there is not a one-to-one relation; as is the case for speech acts in general, interrogative sentences typically perform the act of asking a question, but a question can be indirectly asked also through other structures, e.g., a declarative sentence.

Questions are usually classified as falling into two main types: content questions (e.g., 'What's your name?', 'Where do you come from?', 'How was the show?') and polar ques-

[30] The data collection was conducted at the "Centro di Attenzione al Diabetico" (CAD), Azienda Ospedaliera "Istituti Clinici di Perfezionamento" (I.C.P.), Cusano Milanino. The collection was approved by the Ethical Committee of the center in January 2012. All participants signed a written consent form that authorizes the use of the data. For a description of the corpus, see also: S. Bigi, *Healthy Reasoning: The Role of Effective Argumentation for Enhancing Elderly Patients' Self-management Abilities in Chronic Care*, in *Active Ageing and Healthy Living A Human Centered Approach in Research and Innovation as Source of Quality of Life*, G. Riva – P. Ajmone Marsan – C. Grassi ed., IOS Press, Amsterdam 2014, pp. 193-203; S. Bigi, *Le strutture interrogative nelle interazioni in contesto clinico*.

tions (e.g., 'Is Athens in Greece?', 'Do you know who's coming for dinner?'); a subtype of polar questions are alternative questions ('Is Athens in Greece or in Italy?', 'Are we having chicken or pasta for dinner'?)[31]. Polar questions contain an implicit hypothesis and in dialogues they tend to influence the form of the following turn, thus orienting the dialogue towards certain directions; alternative questions predefine the paradigm of possible answers. Interrogative structures are usually distinguished by: a typical rising intonation[32]; in content questions, the presence of an interrogative pronoun (who, what where, when, etc.); specific characteristics regarding modes, tenses and the order of words in the sentence[33].

For the fact itself of expecting answers, questions appear as typically dialogical structures, set at the interface of syntax, semantics, prosody and pragmatics[34]. For the same reason, they are acts that incorporate presuppositions regarding the epistemic status of the person who asks and the person who is expected to answer[35]. Reactions to questions may be direct answers, but also marked answers or replies[36]. For example, if person A asks, 'Are you going to the cinema tonight?', B may react with a direct answer, 'Yes', or with a reply such as, 'Why do you ask?', or 'I'm deciding later', or even a shrug of the shoulders.

It is not always the case that interrogative structures expect a reply. When this happens, scholars speak of 'non-canonical questions', which are found to often express aspects related to the epistemic or emotional state of those who produce them[37]. Non-canonical questions can best be observed in their sequential collocation within dialogues; indeed, their interpretation as a certain kind of act varies depending on the

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[31] F. Rossano, *Questioning and responding in Italian*, "Journal of Pragmatics", 42, 2010, 10, pp. 2756-2771; G. Gobber, *Pragmatica delle frasi interrogative. Con applicazioni al tedesco, al polacco e al russo*, ISU, Milano 1999; G. Gobber, *Una nota sul contenuto proposizionale delle domande*, "L'Analisi linguistica e letteraria", 19, 2011, pp. 7-32; E. Fava, *Il tipo interrogativo*, in *Grande Grammatica italiana di consultazione*, L. Renzi – G. Salvi – A. Cardinaletti ed., Vol. III, Il Mulino, Bologna 1995, pp. 70-126; V. Dayal, *Questions*, Oxford University Press, Oxford 2016; A. Beltrama – M. Meertens – M. Romero, *Alternative questions: Distinguishing between negated and complementary disjuncts*, "Semantics and Pragmatics", 13, 2020, 5, pp. 1-29.

[32] Although this is not always the case: see F. Rossano, *Questioning and responding in Italian*. As regards intonational patterns of interrogatives in Italian, see also: P. Sorianello, *L'intonazione delle frasi interrogative in due varietà di italiano regionale*, in *Atti del quinto Convegno della Società Internazionale di Linguistica e Filologia Italiana-SILFI*, S. Trovato ed., s.e., Catania 1999; M. Rossi, *Intonation in Italian*, in *Intonation Systems*, D. Hirst – A. Di Cristo ed., Cambridge University Press, Cambridge 1998, pp. 219-238; A. De Dominicis, *Intonazione assertiva e interrogativa a Bologna (e a Roma)*, in *Multimodalità e multimedialità nella comunicazione*, E. Magno Caldognetto – P. Cosi ed., Unipress, Padova 2001, pp. 137-144.

[33] Fava, *Il tipo interrogativo*; V. Dayal, *Questions*.

[34] V. Dayal, *Questions*, p. 1

[35] J. Heritage – G. Raymond, *Navigating epistemic landscapes: Acquiescence, agency and resistance in responses to polar questions*, in *Questions: Formal, functional and interactional perspectives*, J.P. De Ruiter ed., Vol. 12, Cambridge University Press, Cambridge 2012, pp. 179-192.

[36] E. Fava, *Interrogative indirette*, in *Grande grammatica italiana di consultazione*, L. Renzi – G. Salvi ed., Vol. II, Il Mulino, Bologna 1991, pp. 675-720; F. Rossano, *Questioning and responding in Italian*; G. Gobber, *Una nota sul contenuto proposizionale delle domande*; J. Heritage – G. Raymond, *Navigating epistemic landscapes*.

[37] A. Trotzke – A. Czypionka, *Non-canonical questions from a comparative perspective: Introduction to the special collection*, "Linguistics Vanguard", 8, 2022, s2, pp. 205-207.

utterances produced in the previous (e.g., in the case of echo questions) or following turns (e.g., in the case of rhetorical questions)[38]. Moreover, it has been observed that the kind of activity type significantly impacts on the interpretation of the functions played by non-canonical questions[39]. Table 1 summarizes the main interrogative structures and their functions[40].

In dialogues, questions are ways to introduce incomplete or uncertain statements, which require to be completed or confirmed by the interlocutor. This aspect highlights the dialogical, we might say even relational, nature of these linguistic structures, which seem to be made for the purpose of involving somebody else in an ongoing activity. A particularly interesting aspect of this dynamics is the way the paradigm of the possible variables is specified in relation to the conversational common ground of the participants and in relation to the context of the interaction. If, on the one hand, the form of the question projects the kind of expected answer, on the other hand, the relevance of the answer is determined in relation to the context of the interaction. This means that even an apparently 'non-coherent' reply could be accepted as an answer if it allows to infer an implicit component that answers the question coherently[41]. This inference, however, is largely determined by the common ground between the interlocutors and by the constraints imposed by the activity type. Therefore, it is interesting to observe the forms and functions of questions within specific activity types, in particular the institutional ones.

In the specific case of the medical encounter, as mentioned previously (see par. 2.2), the goal of providing expert advice involves at least the processes of assessing, judging and directing. Assessing, in particular, presupposes that certain relevant information has been collected before it can be assessed, i.e. evaluated in relation to general guidelines and specialized knowledge. Indeed, the collection and sharing of information between experts and patients is considered one of the fundamental phases of any clinical encounter[42] and the one in which the complementarity of the 'expert' and 'patient' roles is particularly clear. In this phase, experts need to elicit all the relevant aspects of patients' experience in order to exercise their expertise (see par. 2.1). 'Relevant' refers to information that is related to what is at issue, be it the definition of the disease, its treatment, or other aspects[43]. On the other hand, also patients need to elicit the expert advice they are seeking. In both cases, the functions and forms of interrogative structures seem to be worth observing, precisely

[38] E. Fava, *Il tipo interrogativo*, p. 73.

[39] S.C. Levinson, *Activity types and language*.

[40] Table 1 summarizes the detailed description presented in G. Gobber, *Pragmatica delle frasi interrogative*, pp. 72-112.

[41] G. Gobber, *Una nota sul contenuto proposizionale delle domande*.

[42] E.A. Moja – E. Vegni, *La visita medica centrata sul paziente*, Raffaello Cortina, Milano 2000; D. Roter – J.A. Hall, *Doctors talking with patients/patients talking with doctors: improving communication in medical visits*, Greenwood Publishing Group, Westport 2006.

[43] Exchanges of information that are relevant for rapport building between experts and patients are also important, but they impact on the goal of advice-giving in a more indirect way, therefore they will not be considered in the present discussion.

because they are the linguistic 'instruments' that individuals can use to cope with situations in which it is necessary to obtain from others what they don't have: be it a piece of information, an object, or help of any kind[44].

Table 1 - *The main functions of interrogative structures*

Functions	Examples
Canonical functions	
– ask for information	How old are you? Has Mary arrived? Are you leaving tomorrow or Sunday?
– ask for opinion	What do you think about these exams? Do you agree with him?
– deliberative questions (ask for advice on a line of action)	A: Can I put this away? B: Yes. A: So, do you think I can eat pastries? B: I would not recommend that.
– exam questions (non natural interaction, the answer is known)	So tell me, who fought and who won the battle of Hastings in 1066?
– 'educational' or 'expository' questions (manage the continuation of a text)	So, we have spoken about the different types of morphemes. How should we consider then the lexical morphemes coming from ancient languages and used as prefixes? In these cases we speak of...
– problematic questions (topicalize a problem, but the answer does not exist)	How are they going to solve such a political mess? Will I still have a job next year?
– confirmation requests	You have already heard from the photographer, right? So you've seen what happened?
– leading questions (project a preference for a positive or negative answer, depending on the case)	A: The professor hasn't told you anything yet? B: No, nothing yet... A: Don't you know who she is? B: Actually, no. A: Are you really sure of what you are saying?
Non-canonical functions	
– rhetorical question (expresses a statement)	Will we believe then those who claim the Earth is flat? (hypothetical political speech)
– question with directive force	Will you stop talking?

[44] F. Rossano, *Questioning and responding in Italian*.

Pragmatic blends	
There are cases of sequences that cannot be described as questions nor as directives. Gobber (1999, pp. 100-103) speaks of 'pragmatic blends', which typically realize polite offers and directives.	Could you pass me that dish? Can you help me with this table? Anything to drink? What if we called at Paula's? May I have a look at your glucometer?
In this group are included also 'reactive' questions with echo function[45].	A: Did you talk with Mark? B: If I talked with Mark? A: Did the doctor call you? B: Did who call me?
Sometimes the echo question does not express a question.	A: What? B: What? I'm fed up! A: I usually have cookies for breakfast B: Cookies? Well, this I would not recommend.

3.3 Results of the Analysis

As mentioned in section 3.1, the consultations selected for this study were analyzed first by identifying thematic episodes; then, within each episode, the interrogative structures were identified and their functions described in relation to their position in the turn sequence and in the dialogue. The set of consultations selected for this study included a sub-set of interactions between doctors and patients, and a sub-set of interactions between nurses and patients. The comparison between these two sub-groups yielded some similarities and some differences[46].

One similarity regards the overall structure of the consultations, which appeared to be systematically organized in two main parts: in the first part, participants tended to focus on aspects of the disease; the second part tended to be devoted to planning future actions. Related to this aspect is the second similarity that emerged in the comparison, i.e. the fact that in the second part of the consultation questions were less frequent than in the first part and their main function was that of serving as 'tools' for the coordination of future actions, especially in the form of polar questions:

P_11-3
D: [il sette maggio] alle nove e cinquanta, va bene?
seventh of may at nine fifty, is it ok?

[45] For a more detailed description, see G. Gobber, *Pragmatica delle frasi interrogative*, pp. 105-110.

[46] A few examples are reported here for the sake of clarity. Transcriptions report only some essential features like interruptions, overlaps and elongated sounds; otherwise, they are mainly orthographic and do not represent any phonetic, phonological or prosodic traits. Transcription conventions are reported in the Appendix. Each transcription was archived in the corpus by indicating the number assigned to each patient (for example, P_6) and the number of the consultation with that patient. So, for example, P_6-3 means that this is the third consultation in the corpus with patient 6. Translations of the transcriptions are in italics; they report the meaning of each turn without attempting to reproduce the conversational features of the interactions. P, stands for 'patient'; D, stands for 'doctor'; N, stands for 'nurse'.

P: il sette maggio?
seventh of may?
D: mh è un martedì
mh it's a tuesday
P: va bene.
ok
D: posso confermare
I can confirm

As for the functions of questions, one type could be found throughout the whole corpus, regardless if the consultations were conducted by doctors or nurses: it is the use of questions in sequences aimed at patient education. In these cases, questions can be content questions or polar questions, aimed at highlighting relevant aspects of the disease or of its management; they can also be rhetorical questions used to create hypothetical scenarios where patients are invited to imagine what they would do if something happened:

P_6-3
D: e se tornando a casa le viene una crisi ipoglicemica cosa fa?
what if going home you have a hypoglycemic crisis?
P: eh speriamo di no perché ***
let's hope not because
D: ma metta che le s-
but say it happens
P: sì ha ragione lei non-
yes you are right
D: deve fare attenzione perché questo fa la differenza tra riuscire a cavarsela e no
you should be careful because this makes a difference between managing and having serious problems

Finally, it was interesting to observe that the occurrence of certain types of questions in the first part of the consultations is very similar in the two sub-groups. More specifically, the most frequent type is requests for information ("how are you?", "how are your glycemias?", "are you managing with the diet?"), followed by pragmatic blends and polite directives ("may I see your blood tests?", "did you bring the glucometer?"[47], "could you show me your tests?"). Other less frequent, but interesting, questions are requests for confirmation ("have you looked at the tests?", "have you ever had a diet before?") and for opinions ("what do you think about your glycemias?", "do you think your diabetes has worsened a little?").

Other results from the analysis of the two sub-groups are described separately in the following sections.

[47] In this case, the nature of pragmatic blend appears clearly from the co-text of the question, in particular from the following turns:
P: yes I did
D: perfect (.)
P: here it is

3.3.1 Consultations with the Doctors

In the consultations between doctors and patients, questions are very frequent in the first part of the consultation, used in particular as strategies to begin or to develop thematic episodes. In this function, they appear mostly as content, polar or alternative questions. They can be initiative, i.e., introducing a new topic:

P_6-3
D: come va il suo peso? è stabile [***]?
how is your weight? is it stable?
P: [ma penso che sia sceso] qualche chilo
I think it might have gone down a couple kilos
D: quand'è l'ultima volta che si è pesato?
when is the last time you checked?
P: beh::: quando so stato qui sarà:::
well when I was here last time it must have been-
D: a ott- ad agosto?
in oct- in august?
P: eh
I guess
D: allora dobbiamo andare a pesarci di là. venga con me che la peso un attimo
then we need to go in the other room and check. come with me so I can weigh you

or reactive, i.e., used to respond to a turn uttered by the other speaker:

P_8-1
P: visto che brava che sono no no quando voglio e ma non ho mai fame dottoressa
see how good I am when I want to. but I am never hungry doc
D: come non ha mai fame? [cosa vuol dire]?
what do you mean you are never hungry?
P: [non ho] fame. alla sera a me viene da piangere.
I am not hungry. when it's dinner time I get depressed.

When they are used in the development of thematic episodes, questions appear as the preferred strategies to articulate a reasoning structure that from the collection of information (especially doctors collecting symptoms and information from patients regarding the disease) leads to practical conclusions (doctors' advice):

P_7-2
D: bene. ora dire che eh::: ha portato l'autocontrollo il diario?
ok, so did you bring your measurements, your diary?
P: è molto approssimativo perché poi coi bimbi da curare mi dimentico
it's very inaccurate because when I have the kids I forget
[...]

P: no ho tirato fuori questi qua. poi in alcuni orari durante il pomeriggio non c'è verso che io mi ricordi. proprio non c'è verso questi qui sono
no I took out these. then at certain times of the afternoon there is no way I will remember these here are-
D: e con che frequenza lei si misura?
how frequently do you measure?
P: ecco, più o meno
well, more or less
D: vediamo. allora c'è anche la data. giugno ad agosto una sola volta. A dicembre una sola volta, due
let's see. there are dates. june august only once. december once twice
P: si per- magari poi ho saltato- eh ho sbagliato
yes well maybe then I skipped- eh I did it wrong
D: dice- dicembre no va beh. volta a settimana e le valutazioni devo dire discrete raramente però si controlla
december no well. times a week and the values are ok but you measure seldom
P: un giorno sì e uno no mi dimentico
every other day I forget
D: eh?
I beg your pardon
P: mi dimentico pomeriggio e sera
I forget afternoon and evening
D: eh esatto
exactly
P: mi dimentico
I forget
D: alla sera molto più raramente ma le valutazioni che ci sono- allora qualche volta per piacere può farle anche qui. l'aveva fatto no? due ore
in the evening very seldom but the measures you took- so please some other times could you measure also here. you have done it in the past right? two hours
[...]
D: = [due ore] prima di cena e dopo cena mai
two hours before dinner and after dinner never
P: mai
never
D: **e quindi- facciamola almeno una volta ogni quindici giorni anche due ore dopo cena la valutazione giusto per renderci conto**
so let's do it at least once every two weeks also two hours after dinner this measurement just so we realize

In this extract, the patient and the doctor are discussing the frequency with which the patient has recorded her glycemia values in the diary. These recordings are not sufficient and have been done in a way that is not quite appropriate. The whole extract shows the effort on the part of both participants to make sure they are aligned as to the understanding of the situation. After such understanding has been achieved, the last turn by the

doctor (in bold) expresses a recommendation, i.e. a piece of expert advice, regarding the appropriate and desirable way of recording the patients' glycemia measurements.

3.3.2 Consultations with the Nurses

In the diabetes clinic where the data were collected, nurses had certain specific tasks. In particular, they had to measure patients' parameters (blood pressure, glycemia) and perform a periodical 'diabetic foot screening', aimed at preventing complications caused by the disease. Nurses could not prescribe treatments, but they could plan new exams or direct patients to the doctors or to the dietician for future consultations. These specificities determine the differences that can be seen in the interactions with patients.

Just as in consultations with doctors, questions are used also in these cases to open or develop thematic episodes, but they are also used to coordinate ongoing actions. Indeed, the interactions with the nurses tend to be of a much more 'practical' nature, in the sense that nurses need to 'do things' with patients: so they need to direct their actions, gestures and positions; questions come into play as relevant linguistic devices that contribute to achieve understanding and coordination. In this function, many of the interrogatives used by nurses appear to be 'pragmatic blends', combining polite requests and directives:

P_6-4

N: eccolo qua. allora oggi dobbiam vedere i piedi eh innanzitutto. quindi le faccio togliere le scarpe
right here so today we have to check your feet to begin with. So I ask you to take off your shoes
perché la faccio salire prima sulla bilancia (.) e poi facciamo anche il resto del lavoro
because I'll have you step on the scale first and then (.) and then we do also the rest of the work

P: allora vado sulla bilancia scalzo?
so I step on the scale without socks?

N: viene sulla bilancia con le calze. poi dopo togliamo le calze e guarderò i piedi come stanno
you step on the scale with your socks on. then we take off your socks and I'll check your feet how they are

P: sì sì sì
yes yes

P_9-3

N: tenendo schiacciato il cotone però due o tre minuti e mi sale sulla bilancia così vediamo anche come vanno le- il resto delle-
press down with the cotton for two three minutes and then you step on the scale so we check also how the rest is going

P: tolgo i p- le calze?
should I take my socks off?

N: sì. quali calze scusi che mi prende freddo
yes. sorry what socks you're going to catch cold
P: ah non deve guardare i piedi oggi?
oh so you're not checking my feet today?
N: no no no no::: oggi non- l'abbiamo fatto questo la scorsa volta bravissima
no no no no today we don't we did that last time wonderful

3.3.3 Patients' Questions

In both sub-groups, patients ask questions of various types. The most frequent type are clarification requests, usually in the form of content questions, and both in initiative (P_7-2) and reactive (P_9-3) form, for example:

P_7-2
P: cos'è esattamente la microalbuminuria?
what is exactly microalbuminuria?
D: la microalbuminu- aspetti un momento
microalbuminu- just a moment
P: sì
yes
D: se no- (.) (SCRIVE A PC) la microalbuminuria è un indice di funzionalità renale
otherwise- (.) (TYPES IN THE COMPUTER) microlbuminuria is an indicator of kidney functionality
P: ah
ah
D: che naturalmente fa parte della valutazione del- di tutte le- le complicanze mh?
which naturally is part of the assessment of all the complications mh?

P_9-3
N: dev'essere proprio::: presa questa decisione che l'aiuterà ad abbassare ulteriormente la::: la glicata.
you really need to make this decision that will help you lower more your glycated hemoglobin.
che non può tenerla così alta eh
you can't have it so high you know
P: cos'è la glicata?
what is glycated hemoglobin?
N: la glicata è quel valore che mi dice che le sue glicemie tre mesi prima di questo prelievo
glycated hemoglobin is that value that tells me that your glycemias three months before this test

Another frequent use for questions by patients is in a coordination function, i.e., requests for confirmation regarding things that can or cannot be done in the moment of the interaction, for example:

P_11-2
N: allora. allora questo qui lo possiamo togliere
so. so this one we can take it away
P: ecco
right
N: intanto
in the meantime
P: posso via- mettere via la macchinetta io?
can I put the glucometer away?
N: allora la macchinetta la può mettere via.
so the glucometer you can put it away.

Finally, a very interesting phenomenon regarding patients is what happens when they start narrating something to the experts (be they doctors or nurses). In the majority of these cases, patient narrations are immediately interpreted by experts as implicit requests for clarification or advice. The following is an example of such cases:

P_7-2
P: io ho una- cioè non lo so se dipende dal diabete. per esempio se faccio anche solo una rampa di scale non lunga cioè ho le gambe:::- cioè mi si paralizzano le gambe mi::- come posso dire. cioè mi- mi- mi:::- mi si informicolano tutte. cioè mi prendono e mi informicolano tutte le gambe come se:::- cioè mi- no-n non ce la faccio a fare due rampe. o se vado in montagna per esempio faccio un pezzetto e poi ho le gambe che mi si- le gambe tronche dico io. cioè- che non vanno.
I have a- I don't know if it depends on diabetes. for example if I climb a flight of stairs a small one my legs they get stiff how can I explain they start tingling. I can't climb two flights of stairs. or if I go hiking I go for a bit and then my legs they- they feel like logs they won't go
D: allora questa- questa cosa può dipendere da un ah::: vascolarizzazione periferica a- alterata. Però l'ultimo esame che lei ha fatto- infatti pelle secca perché *** non evidenziava cose particolari polsi percepibili e monofilamento pure era- era buono. ha mai fatto un ecocolordoppler degli arti inferiori?
*Right so this can depend on an altered peripheral vascularization. But the last exam you did- right dry skin because *** it did not show anything particular the pulse could be felt and the monofilament also was- was good. Have you ever had a lower limb ecocolordoppler?*
P: no
no
D: anche questo lo può fare così distinguiamo se è un problema circolatorio oppure [neurologico]
you could do this so we know if it's a circulatory or neurologic problem

4. *Discussion and Conclusions*

Based on the results described in the previous paragraphs, it is possible to develop some considerations regarding the connection between the goals and structural organization of consultations and the functions of the interrogative structures employed by experts and patients.

The first consideration regards the characterization of advice-giving in the context of diabetes care, which, in the analyzed data at least, is achieved through a combination of discourse types. Directing, the form of discourse that more typically expresses advice or recommendations, is usually performed at the end of a sequence in which it is preceded by information sharing between experts and patients and assessing. Especially in the first part of the consultations, this structure often characterizes entire thematic episodes, producing 'micro-advice' on the specific topics introduced either by the experts or by the patients. In this structure – 'information sharing, assessing, directing' –, questions play a significant role. By opening a thematic episode or reacting to a topic introduced by the other participant, questions are used by experts to delve into patients' experience in order to 'extract' the relevant bits, useful to understand the problem more clearly or to identify the most appropriate suggestions. The requests for clarification or confirmation by both experts and patients in these sequences seem to be part of an ongoing effort at achieving shared understanding and alignment on the disease and its management. Experts' questioning in these sequences is surely conducted in a leading style, but it seems to be accepted as such because it directs the dialogue to the formulation of the advice, which draws its reliability precisely on the information obtained in the immediately preceding turns. In these cases, experts' questions contribute to creating the dialogical space for an actual cooperation between them and their patients, who are invited to contribute their experience in view of the institutional goal of producing expert advice.

A second consideration regards the interpretation of patients' narratives as implicit requests for advice: this observation confirms the notion that the activity type has a crucial impact on the inferential schemata activated by the participants and that these schemata are closely linked to the goal the participants assume the interaction to have. These are also instances from which we are able to understand how these participants interpret their own roles within the interaction, confirming the validity of the description of clinical interactions as 'advice-seeking' activity types.

Finally, two reflections regarding questions in dialogue. The first is that, contrary to some accounts[48], but confirming most of the literature on interrogatives, based on our data, the speech act of questioning does not seem to be only aimed at requesting information; it can also be used to request an opinion, confirmation, or advice for action. It is probably more appropriate to consider questions more generally as acts aimed at receiving an answer, i.e. a verbal action[49]. The second has to do with the way questions are analyzed in

[48] V. Dayal, *Questions*, Oxford University Press, Oxford 2016; A. Trotzke – A. Czypionka (2022), *Non-canonical questions from a comparative perspective*.

[49] E. Fava, *Atti di domanda e strutture grammaticali*, Libreria Universitaria Editrice, Verona 1984; the same perspective has been adopted also in G. Gobber, *Pragmatica delle frasi interrogative*; G. Gobber, *Una nota sul contenuto proposizionale delle domande*.

mainstream research on clinical interactions. Based on this (admittedly limited) analysis, it is clear that it is not sufficient to consider only the syntactic form of questions, nor their occurrence in one phase or another of the consultation. It is important to also relate their function to their content, to the roles of the participants, and to the characteristics of the activity type they are used in. This allows to distinguish, for example, two orders of goals in the clinical encounter: the primary goal is that of advice-giving, and it can probably be reached through requests for information; a secondary goal is patient involvement, which can be achieved through requests for opinion or confirmation, which appeared in general as less frequent throughout the corpus.

Clearly these considerations may not be considered conclusive as they are based on a single and limited corpus. A development of the research should explore whether the different functions of interrogatives are signaled through specific lexical items; it should also take into consideration syntactic variation, i.e. whether there might be preferred structures related to the kind of interaction, the pragmatic goal, and the functions of interrogatives. However, the results of this study can be used as an incentive to integrate mainstream research on clinical encounters with a linguistic-pragmatic approach that offers the theoretical and methodological tools for a fine-grained analysis of the functions of linguistic structures in relation to contextual factors, such as the goal, the structure and the roles of participants in interactional events.

Appendix: Transcription Conventions[50]

***	unintelligible speech
-	abrupt stops
:::	elongation
(.)	micro pause
[ ]	overlapping utterances
=	contiguous utterances
?	rising intonation
.	falling intonation
hehe	laugh particle
[...]	*omissis*

Relevant non verbal aspects occurring in the transcriptions have been reported in capital letters between brackets.

[50] G. Pallotti, *I metodi della ricerca*, in *La conversazione. Un'introduzione allo studio dell'interazione verbale*, R. Galatolo – G. Pallotti ed., Cortina, Milano 1999, pp. 365-407; C.J. Jenks, *Transcribing talk and interaction: Issues in the representation of communication data*, John Benjamins Publishing, Amsterdam 2011.

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