“But Basically You’re Feeling Well, Are You?”: Tag Questions in Medical Consultations

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Tag questions have traditionally been discussed as linguistic strategies used by nonassertive speakers. This article reports the findings of a qualitative study investigating the use of modal and affective tag questions by 3 Australian female general practitioners. Analysis of 29 audiotaped consultations revealed that tag questions were used as both control and involvement strategies. They were found to be employed by doctors for their potential to elicit information from patients, to summarize and confirm information, and to express empathy and provide positive feedback. The implications of these findings are discussed in the light of general patterns of doctor–patient communication as well as more efficient clinical interaction.

Tag questions represent an interesting analytical focus for the study of doctor–patient communication because they have been described by various researchers as conducive or leading (Thomas, 1989), as preemptory or closed (Algeo, 1988), and as facilitative or open (Cameron, McAlinden, & O’Leary, 1988). They also constitute one of the most quoted strategies in terms of indirect or nonassertive speech and are thus theoretically at odds with authoritative linguistic strategies. This article explores the use of tag questions by 3 Australian female doctors working in general practice. In particular, I show how tag questions function to establish rapport between doctor and patient yet also to maintain control of the interaction. The insights gained from such a linguistic analysis allow some conclusions with regard

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to the communicative processes involved in doctor–patient interaction and can contribute to more efficient clinician communication. After a brief discussion of the form and functions of tag questions in general, I review aspects of the use of tag questions in health communication before presenting some excerpts from consultations in Australia.

FORM AND FUNCTION OF TAG QUESTIONS

The term tag question refers to the combination of a clause and an auxiliary verb + pronoun + interrogative. The auxiliary is either the primary auxiliary be, have, or do or a modal auxiliary. The negation used in the tag is either n’t or not, however, the latter is uncommon in Australian and American English. The following sentences are examples of tag questions:

1. You aren’t in pain, are you?
2. You can bend your knee, can’t you?

When the clause is declarative or interrogative and includes an auxiliary, this auxiliary remains constant in the tag. When the clause is declarative or interrogative and has no auxiliary, the verb of the clause is replaced by do in the tag, as in

3. You know her well, do you?

There are two types of polarity among tag questions: constant polarity in which both phrases are positive, illustrated in Example 4, and reverse polarity in which one phrase is positive and the other negative, illustrated in Example 5.

4. You’ve survived the weaning, have you?
5. You’ve survived the weaning, haven’t you?

Nässlin (1984) stated that in constant polarity tag questions, the speaker expresses no personal opinion about the truth of the proposition, whereas in reverse polarity tag questions, the speaker believes the proposition to be true.

Bublitz (1979) termed tag questions reduced questions and argued that the functions fulfilled by tag questions in the process of communication were specific to discourse occasions and depended also on prosodic factors, such as intonation. Allan (1986) argued that rising intonation clearly showed the speaker’s orientation toward the hearer and was used when speakers were not speaking with finality or certainty. Thus, tag questions in which speakers indicate that they are checking the proposition with the hearer have a rise or fall–rise tone. Tags by which speakers indicate that they expect the hearer to agree with them have a fall or a rise–fall tone.
As Allan commented, a rising intonation contour is associated with politeness and deference as well as hesitancy, uncertainty, and a lack of confidence. It represents a cooperative strategy by the speaker to ascertain that the hearer is comprehending.

Thus, a falling intonation contour invites agreement from the hearer and tends to constitute a closure of the discourse, whereas a rising intonation contour is more open to disagreement. The rising intonation contour is essentially hearer-oriented and generally associated with deference and uncertainty. By contrast, the falling intonation is typical of assertion and command. Leading questions will be more likely to possess a falling intonation contour because the speaker presumes that the hearer agrees with the proposition.

TYPES OF TAG QUESTIONS

Holmes (1990, 1995) summarized tag question usage according to four categories, depicted in Table 1. Tags were either content oriented (modal), that is, they were used predominantly to satisfy the information needs of the speaker, or hearer oriented (affective). A modal tag has a confirmatory or informative function, for example

1. Doctor to patient: “You’ve been here before, haven’t you?”

An affective tag can be facilitative (Example 2), challenging (Example 3), or softening (Example 4); for instance,

2. Doctor to patient, who has talked about marital problems: “That’s the last straw, isn’t it?”
3. Magistrate to defendant: “You hit her, didn’t you?”
4. Teacher to pupil: “That’s not very tidy, is it?”

Tag questions used for their facilitative function are a cooperative strategy aimed at reducing social distance and expressing solidarity or support. As part of their coercive or challenging function, tag questions force addressees to respond to and

<table>
<thead>
<tr>
<th>Category</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modal meaning (content-oriented)</td>
<td>To express uncertainty</td>
</tr>
<tr>
<td>Affective meaning (hearer-oriented)</td>
<td></td>
</tr>
<tr>
<td>Facilitative</td>
<td>To express positive politeness</td>
</tr>
<tr>
<td>Softening</td>
<td>To invite addressee to participate in conversation</td>
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<tr>
<td>Challenging</td>
<td>To express negative politeness</td>
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<td></td>
<td>To reduce force of criticism and or directive</td>
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<td></td>
<td>To intensify force of negative speech act</td>
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<tr>
<td></td>
<td>To force addressee to contribute to conversation</td>
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</table>
agree with the speaker (conducive tag questions). Acknowledging the ambiguity of some tag questions, Holmes nevertheless maintained that although tags may serve more than one function, it was generally possible to allocate a primary meaning and assign tags to one of the categories mentioned for the purpose of data analysis.

How does all this relate to doctor–patient communication? First, modal tag questions are clearly an effective means of eliciting information from the patient. Second, affective tag questions provide doctors with a valuable tool to establish rapport with patients and to facilitate involvement. Prosodic features, such as intonation and stress, help to fine-tune the utterance—for instance, to diminish the force of a negative comment. At the same time, tag questions give patients a chance to participate in the exchange, to monitor whether the doctor’s assessment represents their own, and to correct any misconceptions. Whether these opportunities are actually realized by patients is a different matter: It has been suggested that patients are reluctant to take the floor and ask questions (Ten Have, 1991).

TAG QUESTIONS AND HEALTH COMMUNICATION

In asymmetrical discourse in which the participants in verbal interaction do not have equal status, tag questions are an important strategy to manipulate interational involvement. Cameron et al. (1988) investigated the use of tag questions in three different asymmetrical settings: in a classroom, in a TV talk show, and during a phone-in between a doctor and a patient. They found that powerless speakers never used facilitative tags but used modal tags almost twice as often as powerful speakers. Hence, affective tags seemed associated with powerful discourse rather than inferiority, as Lakoff (1975) claimed. For both symmetrical and asymmetrical discourse, the person in the role of conversational facilitator (i.e., who was responsible for eliciting contributions from other speakers) in the study by Cameron et al. (1988) seemed to favor the use of affective tags. Similarly, Holmes (1987) found that participants responsible for the flow and success of an interaction (“leaders”) used more tags.

Winefield, Chandler, and Bassett (1989) investigated the use of tag questions during a course of psychotherapy. They found that the female patient used more tag questions as therapy progressed and she gained in self-confidence. According to Winefield et al., the patient’s tags remained predominantly speaker centered (i.e., modal rather than affective) throughout the course of therapy, indicating that the basic asymmetry between doctor and patient had not been disturbed. In addition, they argued that tags following opinions functioned to express the patient’s growing assertiveness and confidence. The authors found that the patient’s tags did not function to yield the floor to the therapist but were used to check the therapist’s response to her views and functioned therefore as appeals to solidarity.

In their study the patient used four times as many utterances as the therapist during the course of therapy. Sequential analysis revealed that the patient’s tag
questions resulted in advice and help from the therapist, who was less likely to merely acknowledge her communication after she included tags in her utterance. In later sessions, tags were occasionally used for their affective function by the patient, especially sentence-medial tag questions, for example, "It is difficult, isn’t it, to understand how it works." In these instances the patient appealed to shared information between herself and the therapist.

Given that therapeutic discourse often involves self-monitoring of speech on the part of the therapist, the male therapist involved in the study by Winefield et al. (1989) explained that he resisted being drawn into doing most of the work in the early stages of therapy. As far as the tag use of the therapist is concerned, he did not use more tags towards the end of the course of therapy than at the beginning, mainly due to his tendency for speech monitoring. This fact would also explain why, given that tag questions can be hearer oriented and function to elicit contributions from them, the therapist in this study did not use many tags in the early stages of therapy, during which he was most reliant on patient contributions.

According to Cameron et al. (1988), the results of their study support the claim that affective tags are the domain of the powerful speaker, used to elicit lengthy responses from the addressee. By contrast, modal tags were used by less powerful speakers to request reassurance and by powerful speakers to gain information. In particular, they found that during the phone-in, doctors used modal tags to establish or summarize the facts of a case and to cut off the caller’s narrative. Although tag questions have been classified as indirect, they are obviously very effective in expressing assertiveness. The significance of tag questions for understanding the process of doctor–patient communication becomes clear when we analyze how doctors actually employ these linguistic strategies.

METHOD

For this study, 29 tape-recorded consultations between 3 female general practitioners and their patients were analyzed with regard to the functions of tag questions. The consultations took place in the doctors’ practices in the Australian state of Victoria and included 11 interactions for Dr. Alice Durham (age 50), 8 interactions for Dr. Belinda Forbes (age 36), and 10 interactions for Dr. Carol Lang (age 42). The consultations were transcribed and coded, using encounter codes allocated by the Community Medicine Program at the Monash Medical Centre, Monash University.

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Transcription conventions: [ ] is overlapping speech; = is lengthened segment; ^ is primary stress; @ is laughter; ... (n) is timed pause; .. is short pause; ((words)) is comments; † is direction of intonation contour; <F F> forte is increased loudness; <H H> high is raised pitch; <R R> rapid is increased speed; <P P> piano is decreased loudness; (0) is latching, no pause; — is truncated intonation unit.
Holmes' (1990) classification of tag questions according to modal and affective function was used for the analysis. As mentioned previously, coding of tag questions can be ambiguous, so to ensure reliability the tag questions were coded independently by three researchers. Multiple functions of tag questions appeared in only two cases overall, but it was then possible to allocate a primary function to those tag questions.

**ANALYSIS**

Overall, the doctors used 98 tag questions, of which 43% had modal meaning, and 55% had affective meaning. Table 2 shows the distribution of tag questions among the three doctors. (It must be noted that the relative paucity of tag questions in the corpus does not allow any statistically significant conclusions.)

All doctors used both modal and affective tags in all major stages of the consultation, and the following linguistic analysis investigates how tag questions shaped the verbal interactions between doctors and patients.

**Modal Tag Questions**

Doctors used modal tag questions mainly to elicit information from their patients about aspects of their medical condition or to summarize medical facts, as in the following excerpts (D = Doctor, P = Patient):

EC31:73F349DT1

D: although,
   ... (13.1) uhm,
   ... (5.7) you were ^on *Aprinox* at one stage,

**TABLE 2**

<table>
<thead>
<tr>
<th></th>
<th>Alice</th>
<th></th>
<th>Belinda</th>
<th></th>
<th>Carol</th>
<th></th>
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<tbody>
<tr>
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<td>%</td>
<td>n</td>
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<td>n</td>
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<tr>
<td><strong>Function</strong></td>
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<td>17</td>
<td>37</td>
<td>10</td>
<td>40</td>
<td>16</td>
</tr>
<tr>
<td>Affective</td>
<td>45</td>
<td>14</td>
<td>63</td>
<td>17</td>
<td>60</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>31</td>
<td>100</td>
<td>27</td>
<td>100</td>
<td>40</td>
</tr>
</tbody>
</table>
[^weren’t you↓]

P: [Ye=sl was].

In this example, the doctor, Alice, uses a modal tag with falling intonation and reverse polarity: the clause is positive, but the tag is negative. These features render the tag question less interrogative: The doctor is summarizing information she believes to be correct and about which she is reasonably certain. Her tag question is a request for confirmation from the 73-year-old female patient, whose response overlaps with the doctor’s. She has not anticipated the doctor’s tag and is ready to answer the question. By contrast, Alice is less certain about her proposition in the following exchange with a 30-year-old male patient:

EC29:30M349DT2

D: .But ^when did you get him?
   At the ^weekend,
   → was it↑

P: Uhm yeah,
   this ^weekend.

Alice wants to know on which day her male patient had access to his son, who had arrived from Sydney. After a direct WH-question ("When did you get him?"), she uses the rising intonation tag to elicit information that she genuinely does not possess. The tag shows constant polarity in that both the clause and the tag are positive sentence types. However, her tag serves to direct her patient’s reply as a cue towards the answer that she assumes is correct and so has a more conducive effect. The combination of the two questions has a “cluster” quality and thus conveys a sense of impatience on the doctor’s part. Paradoxically, the tag also softens the impact of the question. The interrogative nature of the tag is emphasized by the rising intonation contour, which carries with it a strong appeal to the patient to respond. Alice’s patient replies to her question, prefacing his response with a hesitation marker.

Similarly, the second doctor, Belinda, used modal tag questions to confirm information pertaining to the patient’s medical condition:

EC25:53M394DT3

D: .Alright,
   a=nd.. ^I’m just wondering,
   you’ve still got your ^machine at home,
   → ^haven’t you ↓
P: Yeah.
D: (0) For your ^blood pressure?
P: Mhm.

The function of the modal tag with its reverse polarity and falling intonation contour is to satisfy the speaker’s information needs and it elicits the desired response from the patient. Again, the doctor is reasonably certain about her proposition, as signalled by the falling intonation contour. Although the patient confirms her assumption, she follows up quickly with a clarification of her tag question.

The third doctor, Carol, used the modal tag effectively to provide her patients with a chance to talk about any additional medical or psychological concerns. A typical example is given here:

EC1754M429DT2

D: @,
.. so=,
, but ^basically you’ve been feeling well,
→ <R. have you↑R>
P: (0) <H Oh yeah H>.
.. I don’t feel ^any .. measurable .. pain.
... (1.7) Happy ^enough I think.
D: <P Good P>.

Here the modal tag question serves to elicit information from the patient and gives him the opportunity to mention any concerns about his health. The rising intonation contour reinforces the interrogative nature of the utterance. At the same time, Carol seeks confirmation that the patient feels fine overall. In fact, Carol uses this particular type of tag question several times with other patients, usually prefacing it with but. The pragmatic particle points forward in this case, away from previously raised health issues to direct talk to other relevant business. The brief hesitation that precedes the tag highlights the elicitative function of the modal tag question in this case.

The constant polarity feature gives the patient the possibility to disagree with the doctor’s assumption, which is stated in the clause preceding the tag. Constant polarity, like rising terminal intonation, emphasizes the interrogative aspect of the utterance, especially when it contains a rising intonation contour. Although it can be argued that Carol is leading the patient to reply in the affirmative, the constant polarity tag opens up the exchange for disagreement. The less categorical nature of the clause is also expressed by the adverbial hedge basically. However, rather than expressing uncertainty, the modal tag here provides an opportunity for the doctor to elicit necessary information from the patient. By using the modal tag in this way,
the doctor reduces social distance and provides patients with an opening to contribute to the discussion about their health.

Affective Tag Questions

The doctors frequently used affective tags in their facilitative function to express empathy and alignment with their patients. At a later stage in the same consultation while examining the patient’s stitched hand, Alice comments on the condition of the wound:

EC27:65M349DT2

D: .Now that’s looking ^good,
→ ^isn’t it ↓
P: I —
   I —
   I yes,
   it doesn’t —
   you know the couple of times I’ve ^seen it,
   it ^looked quite —
   … even ^despite the fact that I hadn’t been,
   taking me medication as regular as I ^should,
   not because I ^didn’t ^intend to,
D: (0) That’s the te-
tenth,
^wasn’t it↓

She empathizes with the patient about how well the hand is healing, the implication being that the patient is looking after it well. The tag functions here as an instance of positive politeness and by implication as praise for the patient. He in turn replies hesitatingly, with several false starts, and the reason for this is revealed when he confesses that he has not always taken his medicine. Alice seems to ignore this completely, because she proceeds to ask him for the date when his injury occurred, phrased as a modal tag question. She does not refer back to what her patient has said; instead she introduces a new topic immediately after he has finished his turn ("latching"). The falling intonation contour on the tag indicates that here the use of the tag question is predominantly phatic, with the doctor not expecting agreement from the addressee.

Alice also uses the affective tag in a preemptory way as a means to ward off pressure from the mother of a 2-year-old girl who is visiting the practice for the first time. The child has been vomiting for the last few days and is very weak, and
the mother is very upset. When the doctor fails to make an outright diagnosis and refers the child to a pediatrician, the mother continues to press for information:

EC26:02F349DT3

M: [It's just not] normal,
to vomit every few days.
D: . No.
M: And she just seems to be getting worse,
I mean —
... (10.1) ((UNINTELLIGIBLE DUE TO TRAFFIC NOISE))
If the other one gets it —
D: Well.
.. we'll have a better idea,
→ won't we↓
M: . Yeah.

At this stage the patient's mother is very concerned about her daughter's condition. Alice is in the process of writing the referral letter as the mother continues to talk about her concerns. The doctor's affective tag accomplishes several things at once: First, it serves to cut off the mother's list of worries without being openly impolite; second, it excludes her from the decision-making process through the personal pronoun we as the doctor draws on the authority of the medical community; and third, it forces the mother to agree with the doctor. The falling intonation contour of the tag question emphasizes the categorical closure of the sequence and makes the reading of the personal pronoun as a marker of solidarity unlikely. Here, the affective tag is not so much a device for the doctor to align herself with the patient, but for the patient to be aligned with the doctor. The doctor is no longer interested in discussing the issue and uses the tag question to close the topic, but the mother continues to pressure her for a diagnosis even though it is clear that Alice does not know what is wrong with the girl. The mother's continued remarks constitute a potential challenge to the doctor's authority. By using the affective tag, Alice cuts off any further challenges from the mother.

Belinda used not only affective tags to express solidarity with her patients but also self-disclosure, as in the following excerpt from a consultation with a 31-year-old female patient:

EC19:31F394DT4

P: .. My father has osteoporosis [sic],
   my mother had rheumatoid arthritis,
D: and cancer,
.. uhm .. no,
   apart from ^arthritis,
   no @ @
D: . I've got that in ^my family too.
P: Oh.
D: It's an ^awful thing,
   ^isn't it ↓
P: It doesn't ^help,
   no.

As asked whether there are any severe illnesses in her family, the patient lists a number of conditions and the doctor discloses that one of them—arthritis—also runs in her family. The patient acknowledges the information with an information management marker (oh), indicating that the information is news to her, and Belinda continues with an affective tag question, expressing empathy and eliciting agreement from her patient. The tag question shows a falling intonation contour that reduces its interrogative character and signals that the speaker is appealing to shared knowledge. Self-disclosure by the dominant speaker does not occur often in institutional discourse. Coates (1993) described self-disclosure as characteristic of talk between women friends, in which it signals intimacy and solidarity. In this particular case, it reduces the distance between doctor and patient. It can, of course, be used as a powerful strategy to encourage patients to disclose issues in return.

Finally, Carol's use of affective tag questions demonstrates how they can provide feedback and signal attentiveness by the doctor and thus encourage patients to continue with their turn. In the following example, Carol is talking to a 25-year-old female patient, who has finally become pregnant:

EC1925F429DT1

P: . I'm really ^rapt Carol,
D: . Yes,
   <H it's ^good,
   ^isn't it H ↓
P: . Uhm,
   I'm a different person now,
   I'll —
D: Yeah.
P: compared to two ^years ago.

In this example, the affective tag shows a falling intonation contour as well as increased pitch. The doctor is providing positive feedback, sharing the patient's joy
at her pregnancy. The patient recognizes it as phatic and continues her train of thought, rather than treating it as a genuine request for information. The affective tag question signals to the patient that the doctor is not just interested in her medical but also her psychological well-being.

Although this study is concerned with doctors’ use of tag questions, it makes sense to discuss briefly the use of patients’ tag questions. Most importantly, perhaps, is the observation that the patients who participated in this study used almost no affective tag questions, which confirms findings reported in the literature. It appears that the asymmetrical relationship between doctors and patients and the ritualized nature of their encounters means that affective tag questions are the domain of the doctor. It is not up to the patient to demonstrate solidarity, express empathy, or reduce social distance: These moves are initiated by the more powerful speaker.

CONCLUSION

This study shows how women doctors used tag questions on one hand to maintain control of the consultations and on the other hand to align themselves with patients. They used tag questions as linguistic strategies that served as means to an end: the diagnosis of conditions and their treatment or management. In other words, they were a discourse strategy that helped them realize themselves as competent professionals within the framework of the medical consultation. Given that the medical consultation has clearly defined parameters that both doctors and patients are aware of, the expectations brought to the encounter by both parties will affect their discourse structure. Tag questions played an important part in how interactional control and involvement, respectively, were realized in face-to-face interaction. In this manner, doctors were able to decrease social distance in an attempt to present themselves as active and sympathetic listeners, and patients responded by volunteering information.

Modal tag questions provided doctors with a valuable linguistic tool to summarize medical information and to elicit confirmation of information from their patients. In addition to serving the information needs of the doctor, it also provided patients with an idea as to how their doctors saw and thought about their condition. By giving patients the chance to respond, doctors also opened up the discourse to them, offering them an opportunity to either talk about additional problems or to correct the doctor’s version of their condition. It must be kept in mind that these initiatives came from the doctors, which means that the essentially asymmetrical character of the consultations was not challenged.

Affective tag questions were a very effective way of showing that the doctor was genuinely concerned about the patient’s physical and psychological well-being. All three doctors used these types of tag questions to express empathy, acknowledge their patients’ experiences, appeal to shared knowledge, and even
show solidarity. When necessary, however, doctors also used affective tags to close off the interaction and direct it towards a new topic. They can obviously function as a powerful linguistic strategy, especially in combination with the personal pronoun we, which is still used by practitioners when they perceive the need to refer to the authority of the institution of medicine. Clearly, doctors as well as patients need to protect face, but the use of tag questions as a means to cut off patients’ questions, comments, or even challenges can easily be interpreted as patronizing.

Practitioners who are aware of the role that tag questions can play in eliciting information from patients or in establishing rapport with them have at their disposal a valuable linguistic tool. Tag questions are not necessarily leading questions: They can indicate to patients that their concerns are taken seriously. In the linguistics literature, tag questions used to be associated with nonassertive talk. This study indicates that tag questions are much more versatile than that, and future research should focus on the use of different types of tag questions by male practitioners to determine whether gender makes a difference.

REFERENCES


