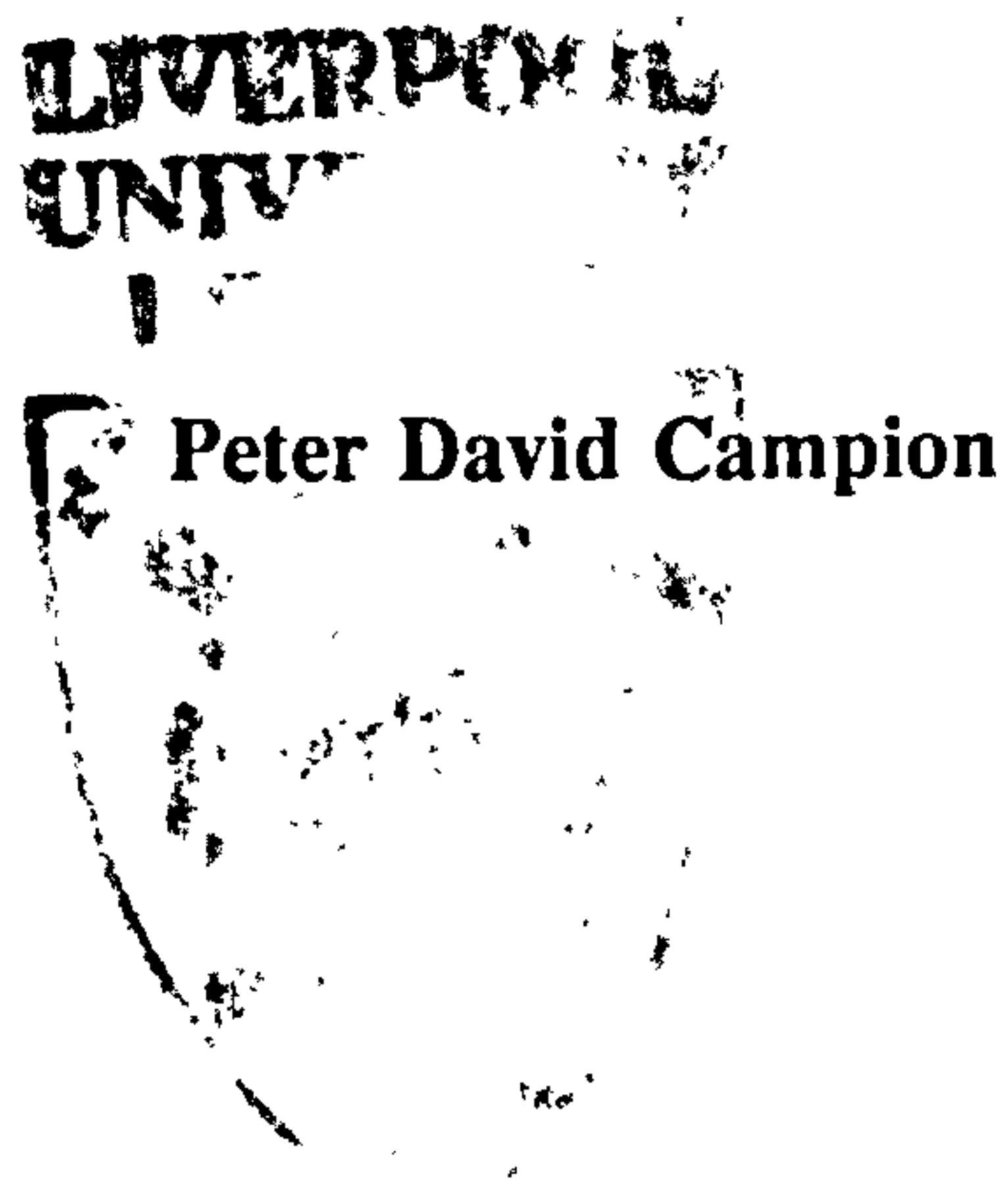


**On Structures in Medical Interactions**

**A Conversation Analytic Study of General Practice Consultations**



**Thesis submitted for the degree of Doctor in Philosophy**

**at the University of Liverpool**

**in the Faculty of Social and Environmental Studies**

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## PREFACE

This thesis has had a long gestation: it was conceived in 1989, when I first began systematically collecting video-recordings of general practice consultations, although the "gleam in the eye" had first appeared much earlier, during my time as lecturer in General Practice at the University of Dundee in the early 1980's under Professor Jimmy Knox. But it was without doubt the reading of an article in the British Medical Journal by Dr Christian Heath, on the subject of interaction between doctors and patients, which triggered the start of this work. Subsequent meetings with him, and access to the emerging literature of Conversation Analysis, enabled me to enter a scientific paradigm distinct from but no less rigorous than the conventional hypothetico-deductive "constructivist" paradigms of most medical and bio-psycho-social research.

The work is empirical rather than theoretical, that is, it is based on observational data, and the analysis is itself particularly "empirical", in that it follows a tradition of sociological enquiry, "ethnomethodology", which is itself grounded in empirical data. This is fully described and discussed in the thesis' opening chapters.

All references to the work of others are fully cited and indicated in the text by quotation marks and indents. All references listed have been personally consulted by me. I am indebted to my supervisor, Dr David Hall, of the Department of Sociology, University of Liverpool, for his unfailing support and enthusiasm, especially at those (too frequent) times when I felt I would not complete the work. His familiarity with the wider sociological world was invaluable. David Greatbach, Christian Heath, Rod Watson and

Carl May have at different times provided advice, encouragement, and access to their collections of literature, and to them I give sincere thanks.

I acknowledge a great debt to the John Rylands University Library of Manchester, where I found almost all the relevant literature, and was accorded reciprocal borrowing privileges.

My partners in The Park Road Group Practice have graciously tolerated my frequent absences, especially during the period of study leave in 1994, and have willingly allowed their clinical work to be video-recorded for this and other research projects. Finally I acknowledge the many patients who have consented to their consultations being recorded, trusting that I would respect their confidentiality, without whom this work could not have been done.

I dedicate this work to my wife Janet, who has been my greatest support, and to Daniel, Emma, Tom, and Rachel, who might see a little more of their Dad now it is completed.

Peter Champion, August 1994

## **"On structures in medical interactions"**

**Peter D Campion**

### **Abstract:**

This thesis addresses from within the research paradigm of Conversation Analysis (CA) the question "How are interactions between patients and general practitioners organised?". CA is a relatively recent tradition within the "interpretative paradigm" of sociology, growing out of the ethnomethodology of Garfinkel. The thesis first reviews the relevant literature of CA and medical interactions, and critically discusses the methodology.

The empirical analysis used naturally occurring consultations in British general practice, video-recorded in five practices, involving 14 doctors, and about 50 hours of recording, made between 1987 and 1992. Recordings were observed first in an unmotivated way, to note occurrences of interesting interactional phenomena. Objects for further study were copied onto secondary "collection" tapes, which were then examined in depth, and transcribed in detail using conventions developed within CA.

The analyses described here are: the use of time in the consultation; the impact of medical records on the interaction; prescribing and associated talk; the phenomenon of "facilitation", how doctors appear to enable patients to talk; patient-initiated questions, and rejection of patients' ideas by doctors; and finally the use of the word "we". The aim was to describe and explore, but not necessarily to explain, although in describing the mechanism of interaction in these areas of activity, empirical evidence is advanced for particular explanations.

The phenomenon of patients raising new topics at the end of consultations is described, with its interactional implications: the "by-the-way" phenomenon is explored and documented. Case-notes are seen to contribute to consultations in a complex way, and like talk, are both context-dependent and context-forming. Utterances such as "right", "uhuh", "mmhm" which appear on the face of it to be facilitatory, can be the reverse. The phenomenon of dispreference for disagreements by patients is re-examined, and contexts in which patients do disagree are explored. Doctors' rejections of patients' ideas are described, and implications for teaching about the consultation are drawn. Finally the various ways in which the word "we" is used by doctors are described and critically appraised, in the context of a philosophical understanding of "intersubjectivity".

The study adds to the body of transcribed interactions drawn from general practice, and sheds some light on ways in which general practitioners and patients structure their consultations. It has implications for the way medical students learn how to consult, and for how research on the consultation can be conducted. Conversation analysis is shown to be a powerful qualitative analytic methodology, relevant to the study of medical interactions.

### **Glossary of some terms used in Conversation Analysis**

- "action"** anything a member does, including utterances: also "practical action"
- "adjacency pair"** two utterances which are related by commonly-agreed rules (see text)
- "data"** human interaction recorded (normally on audio- or video-tape) and transcribed according to agreed conventions
- "first pair-part"** the first part of an "adjacency pair"
- "formulation"** conversationalists' practice of "saying-what-we-are-doing-in-so-many-words"
- "indexical"** an expression (word, phrase) which depend on its context for meaning
- "member"** a person in society
- "objective"** contrasted with "indexical", does not depend on its context for meaning
- "phenomenon"** any instance of an action which can be described and compared with others
- "reflexive"** the property of members' actions (and hence talk) to relate to their context (ie to be "indexical")
- "transcript"** the written representation of data, using an agreed convention
- "third turn"** a first speaker's second turn, after second speaker's response to a first pair-part of an "adjacency pair" (q.v.)
- "utterance"** any unit of vocal expression, from a single sound, a syllable, word, phrase, clause, sentence, or more



## CHAPTER 1: INTRODUCTION

### Theoretical introduction to thesis.

"A gross observable feature of encounters between physicians and patients is that they proceed largely through the ongoing accumulation of exchanges of dialogue"

(Frankel 1989)

"On structures in medical interaction" represents the fruit of an investigation begun as soon as I realised that video-recorded consultations constituted a source of almost infinite discovery about the medical process, and which will not end until I retire! The ability to examine, and re-examine one's own professional activity, as done by oneself and others, could be thought the height of narcissism. However, if the motive is that of science: to advance knowledge and understanding, and the method is observably open to scrutiny (I avoid the term "objective" for reasons which should become apparent), and rigorous, then this is "research" in its original sense of, literally, to "search again".

### Ethnomethodology

"Ethnomethodology" is the name, coined by Garfinkel (1967), given to that school of sociological enquiry which he developed with others (see Heritage 1984, 1987, and Sharrock and Anderson 1986 for historical perspectives) and which became the subject of great controversy within academic sociology (see for example Watson and Sharrock



1991). It can be located within the "interpretative paradigm" of social theory (Burrell and Morgan 1979).

Garfinkel summarized his aim in ethnomethodology as the study of "the essentially practical methodology for making sense of the world in order to act in it" (Garfinkel 1967), and stated:

"I use the term "ethnomethodology" to refer to the investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organised artful practices of everyday life."

Here Garfinkel sets out his agenda, in terms of "indexical expressions" (the everyday usage of language that depends on context for meaning), implying that, contrary to the conventional scientific view, these do possess "rational properties". He includes "other practical actions" in his statement because again, in contrast to the conventional sociology of the time, he regarded commonplace everyday activities (such as living at home, or playing games) as possessing systematic organization which was open to scientific analysis. His hypothesis was that these phenomena were "contingent ongoing accomplishments", in other words, they depended on the context, and indeed on themselves, for their existence: they were "organized, artful practices".

This radical agenda marked ethnomethodology out as "different", and in a sense, threatening, because it challenged the conventional view that sociology was about observing the natural world of human activity and through an external "scientific" process involving theories and methods, drawing conclusions and generalizations which were not evident from the observations themselves. Garfinkel believed, and by his classic "breaching" experiments showed, that the world could be explored through the methods of members themselves (hence "ethno-methodology").

Thus ethnomethodology is fundamentally different from other schools of social science, and cannot easily be reconciled with them (Sharrock and Anderson 1987). Sociological inferences need to be strong, in the sense of supported by reference to observable events. Jefferson quotes from Sacks' unpublished lectures (Jefferson 1985) "the detailed

study of small phenomena may give an enormous understanding of the way humans do things, and the kinds of objects they use to construct and order their affairs." Thus the approach of ethnomethodology to questions about the construction of everyday life and human interactions is to explore those interactions in detail, and to use *replicable methods* of analysis to infer meanings and explanations.

The intellectual antecedents of ethnomethodology and conversation analysis (see below) are well described by Goodwin and Heritage (1990), in which they refer to the juxtaposition of two emergent trends in sociology, the phenomenology of Schutz (1964, 1967), and the interactionist "context analysis" of Kendon (1982) and others. They wrote:

"Though they (Sacks and Schegloff) refracted these two influences somewhat differently, the discipline of conversation analysis essentially emerged as a fusion of the interactive and phenomenological/ethnomethodological traditions. Within this fusion, interactional materials would be used to investigate the procedural bases of reasoning and action through which actors recognize, constitute, and reproduce the social and phenomenal worlds they inhabit." (op cit p.286-7)

Schutz' profound influence is typified in the following:

"even the simplest interaction in common life presupposes a series of common-sense constructs" (Schutz 1967, p.23)

and, "We propose to use the term 'sign' for designating objects, facts, or events in the outer world, whose apprehension appresents to an interpreter cogitations of a fellow man.....The objects, facts, and events which are interpreted as signs must directly or indirectly refer to another's bodily existence. In the simplest case, that of a face-to-face relationship, another's body, events occurring in his body (blushing, smiling), including bodily movements (wincing, beckoning), activities performed by it (talking, walking, manipulating things) are capable of being apprehended by the interpreter as signs." (op. cit p.319).

An interesting commentary on the ideological quarrels between ethnomethodology and other sociologies is given by Anne Rawls (1989) in her essay "An Ethnomethodological perspective on social theory". She argues that ethnomethodology represents a "radical middle ground" between extremes of subjectivity and positivism. It offers an understanding of "meaning" neither in terms of "structures in minds" (the extreme subjectivist position) nor in terms of "a real representation of the world out there" (the positivist stance). Rawls argues that ethnomethodology shares with classical social theorists such as Durkheim and Weber the notion of "social construction" as applied to ideas of "self" and "knowledge". She recognises both institutional organization and non-institutional organization at work: she uses the phenomena surrounding turn-taking as examples of non-institutionally organised activity, rather of interactionally produced emergent organization, but recognises the formal "institutional" organization of talk and meaning as well. She calls these two domains of social order as (1) emergent interactive meaning and (2) retrospective institutional accountability frameworks. Far from reducing the argument to either institutional or interactive, she sees a middle ground which is ethnomethodology.

"Ethnomethodology's contribution to the detail of our understanding is not really a matter of dispute. The challenges to ethnomethodology have centred rather around what could be done with the detail once it was understood".  
(Rawls 1989 op.cit. p.18)

In terms of this thesis, the institution of "medicine", with its "doctors", "patients", "pharmacists", "nurses", "illnesses", "symptoms" and so on is irrevocably bound up with the interactive work of generating meaning in-the-course-of-the-consultation, where that meaning is totally unique, indexical, and frequently reflexive. I share Rawls' ease in recognising both aspects to human activity, but prefer to work with the interactive "micro" domain, because it is inherently more accessible to observation and analysis.

## Conversation Analysis

The precise methodology on which this work is based has become known as "conversation analysis" (Sacks, Schegloff and Jefferson 1974, Goodwin and Heritage 1990), hereafter sometimes referred to as "CA". As non-vocal components of communication gained prominence in the analyses, the term "interaction analysis" was also used (Heath 1986, also Heritage 1991). CA takes as its "substrate" or starting point the audio- or video-recordings of everyday human interactions, and commonly refers to this material as "data". By using recorded events, the analyst allows *replication* of any analysis and interpretation of the data.

In taking as its source recorded data (audio- or video-tape, or transcripts of these) of everyday interactions, and without making prior assumptions about significance or meaning, the methodology seeks to describe and explain the observable local organization of the practical actions of the speakers. Conventions of transcription and analysis of speech (Jefferson 1984) and movement (Goodwin, 1981 Heath 1986) have been established, and are used in this thesis. A key is provided in Appendix 1.

The work of Christian Heath (1986, 1989) has been particularly important for me, firstly as I noted in the preface, because it was through reading his summary of "Body movement and speech in medical interaction" in the British Medical Journal that I discovered this approach to science, and the study of human interaction, and secondly because that book has served as a model for my analysis of consultations. He had access to some very early video-recordings of doctors and patients, made through the Department of General Practice at Manchester, and his work laid the foundations for succeeding studies of this context. He has particularly developed the study of non-vocal activity in interaction, both gross and fine movements, and my analyses of these phenomena are directly drawn from his methods. I argue elsewhere that the medical context is only incidental to the essential findings of this study, which are as relevant to other interactions as to doctor-patient ones. Since publishing "Body movement and speech in medical interactions" Heath has studied a range of other contexts, using the same methodology, and is now collaborating with this author and others in re-examining

the medical interaction since the advent of the desk-top computer (Greatbach et al 1993).

### Harvey Sacks and Conversation Analysis

Harvey Sacks, who worked in California in the 1960's and 70's, and was killed in a road accident in 1975 (see the introduction to volume 1 of the "Lectures", (Schegloff 1992)) has become, posthumously, one of the seminal authors within the conversation analysis tradition. He explored the observability of human activities, and the way members, and social scientists, make inferences from these. His lectures, now published, edited by Jefferson (Sacks 1992) covered an extraordinary range of themes, and, circulated in the unpublished form of duplicated transcripts, laid the groundwork for the now well-established school of conversation analysis.

In a lecture in 1967 he explained his use of tape-recorded materials as follows:

"So I started working with tape-recorded conversations, for the single virtue that I could replay them; that I could transcribe them somewhat and study them extendedly - however long it might take..... It wasn't from any large interest in language, or from theoretical formulation of what should be studied, that I started with tape recorded conversation, but simply by virtue of that I could get my hands on it and I could study it again and again. And also, consequently, that others could look at what I had studied and make of it what they could, if, for example, they wanted to be able to disagree with me."

(cited in Psathas 1990b p.24, also in Sacks 1992 Vol 1, p.622)

Data for CA was initially acquired opportunistically (cf Sacks' own account cited above), as for example, routinely recorded telephone conversations with radio stations, or with emergency services, and were used because it could be argued that any naturally-

occurring<sup>1</sup> speech was valid material (see for example, Sacks' use of group therapy sessions, Heritage and Greatbach's (1991) report of news interviews, Sharrock and Anderson's (1987) work in a hospital clinic, Heath's (1986), ten Have's (1989, 1991) and Greatbach et al's (1993) studies of general practice consultations ). Among Sacks' own sources was a series of recorded telephone calls by members of the public to an emergency suicide prevention service, and thus comprise a (somewhat atypical) set of doctor-patient consultations (Sacks 1992 vol 2 p.376). As the subject developed, and early studies established the "ground rules" for human speech interaction, the origin of the data became more salient. Patterns emerged of differences in the structure of interaction in different contexts (see for example, ten Have 1989, Watson 1987, or Greatbach and Dingwall 1989). The selection of data became an important part of any study (see Silverman (1993) for a discussion of rigor in data selection).

Sacks in his published lectures (Vol 2, p.215) introducing the course to a new set of students, says:

"The loosest message is that the world you live in is much more finely organized than you'd imagine."

and: "The core question is how do people go about doing 'being an ordinary person'?".

The central premises of Conversation Analysis were described by Schegloff and Sacks (1973) in one of the most significant early CA publications thus:

"We have proceeded on the assumption (an assumption borne out by our research) that insofar as the materials we worked with exhibited orderliness, they did so not only for us, indeed not in the first place for us, but for the coparticipants who had produced them. If the materials (records of natural

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<sup>1</sup>By "naturally-occurring, I mean not being constructed *by* or *for* the purpose of the research (as is the case with research interviews). I realise that sociologists with a constructionist perspective would argue that any institutionalised interaction, of which a medical encounter is a paradigm, is not naturally-occurring, but constructed.

conversations) were orderly, they were so because they had been methodically produced by members of the society for one another, and it was a feature of the conversations that we treated as data that they were produced so as to allow the display of the coparticipants to each other of their orderliness, and to allow the participants to display to each other their analysis, appreciation, and use of that orderliness. (p.290)

That is to say, firstly, that everyday behaviour, in particular as encapsulated in and represented by electronically recorded speech and actions, constitutes a valid and appropriate subject for systematic scientific study, and secondly that the methods deployed in such an analysis can be derived from the activities found in the recorded data itself. I was especially interested to note that Sacks had begun, in 1973, following a meeting with the Goodwins, to work with video material (Schegloff 1992), having previously used only audiotape. His death in 1975 precluded the publication of any of this work, but from the direction of Goodwin's subsequent writing (Goodwin 1981) and the acknowledgements in both his and Heath's (1986) work to Sacks suggest that there is no discontinuity between the handling of Sacks' audiotape data and later video-tape material by others.

Conversation analysis operates within the premises (even "canons") of ethnomethodology, concentrating on the analysis of language (and para-language) only insofar as everyday action is organised and mediated largely through language.

The characteristics of everyday speech which make it appropriate for such analysis are its "indexicality" (depending on the context for meaning), (Garfinkel 1967, Garfinkel and Sacks 1970) and its "reflexivity" (relying on commonly taken-for-granted meanings of words and expressions.) The terms "indexical" and "reflexive" are themselves derived from linguistics, but have acquired distinctive meanings within ethnomethodology. (See below for a discussion of the relationship between CA and linguistics.)

Indexical expressions are concerned with the uniqueness and specificity of their objects: they form the major part of everyday speech. They are contrasted (in conventional

linguistic theory) (Garfinkel and Sacks 1970, p.349) with "objective" expressions, proper nouns, terms which need no context for meaning, that can be defined externally (for example, "the prime minister", "tuberculosis", "social class") and which might be used in positivistic methodologies to explain events otherwise described by actors in indexical terms. Indexical expressions indicate their relationship to their setting by their context. By "relationship with their setting", is meant the accompanying motives, purposes, histories of the speakers. For ethnomethodology, such indexical expressions can be regarded as sufficient and appropriate in their own right as descriptors of events.

Garfinkel (op. cit) also described talk as "reflexive", in that it forms an integral part of the social world it describes. Wilson (1991) comments on the corollary of this:

"Thus we must abandon any standard Durkheimian conception of social structure that takes externality and constraint for granted as a methodological stipulation. Rather, externality and constraint are members' accomplishments and social structure and social interaction are reflexively related, rather than standing in causal or formal definitional role in relation to one another" (p.27)

The "reflexivity" of talk is its interrelationship with its context: the talk itself displays and reflects the social construction of the context:

"That reflexivity assures to natural language characteristic indexical properties such as the following: the definiteness of expressions resides in their consequences; definitions can be used to assure a definite collection of "considerations" without providing a boundary; the definiteness of a collection is assured by circumstantial possibilities of indefinite elaboration." (Garfinkel and Sacks 1970 p. 338)

This characteristically opaque passage seems to mean that natural language (the "substrate" of CA) is "reflexive" because it (a) defines its meaning as it unfolds, so a study of the *context* of a word or expression is essential to discover its sense; and (b) that therefore while it is possible to define objects (activities, speech or otherwise) for



the purpose of collecting them together, it is never possible to be all-embracing or limiting, because of the infinite number of different contexts on which such objects depend.

**Ethnomethodology contrasted with other forms of sociology:**

In "The Structure of Social Action", Parsons (1968) acknowledged the epistemological alternative to positivism, which he caricatured as "idealistic empiricism" (p.477), as involving "the repudiation of all such (systems of analytical) theory in favour of the concrete uniqueness and individuality of all things human." Since Parsons, the gulf between sociology in the tradition of Sacks, Garfinkel, Jefferson, Goodwin, Heritage, ten Have, Heath, Greatbatch and other conversation analysts on the one hand, and other sociological streams on the other, has become deeper, in the absolute freedom of the former from frameworks and theories created by other sociologists<sup>2</sup>. Thus Garfinkel and Sacks (1970) wrote:

"Irreconcilable interests exist between constructive analysis and ethnomethodology in the phenomena of the rational accountabilities of everyday activities and its accompanying technology of practical sociological reasoning" (p.340)

Ethnomethodologists, while drawing on previous authors for contrasting methodologies, or to establish the antecedents to their position, need not, indeed cannot draw on prior theory for explanation of the phenomena under discussion, since any theory must be derived from the actors' understanding as found within the data corpus itself. When the material has been explicated, it may then be appropriate to compare the understanding offered with parallel explanations from alternative methods, (see for example, the quotations of Schegloff and Sacks, and Sacks, at the start of Heath's (1986) first chapter). Garfinkel and Sacks refer to the goal of "all sciences" to "remedy indexical

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<sup>2</sup> But note the discussion of Rawls' views on p.4 which appear to offer a bridge across this widening gulf.

expressions", in the sense that they (scientists) assume that the substitution of objective for indexical expressions is programmatically relevant. However others, such as Rawls (1989, cited above, p.4), have sought to find common ground, or rather to see ways of making use of the insights of ethnomethodology without rejecting all "constructionist" thinking. Such eclecticism is certainly easier to live with in the academic environment of a medical school than would a "purist" position.

### Other approaches to medical interaction

The extent to which a member of a professional group, such as a general practitioner, is prepared to accept a patient's "lay" account of an illness, its perceived cause, and the actions taken, will affect the professional's understanding of the problem (Tuckett et al 1985). Doctors are trained to "take a history", the process of establishing the chronology and (medical) category of the symptoms (see Byrne and Long 1976 p. 19, Cassidy 1938); to perform a "physical examination"; to arrange certain tests; and finally to arrive at a "diagnosis". Many studies have shown differences between doctors and patients both in the way they view illness (in "objective" or "indexical" terms), and in the very content of the ideas about illness (termed "explanatory models" by Kleinman et al (1978)).

Byrne and Long's "Doctors talking to patients" (1976) was a seminal work in the development of the study of doctor-patient communication, cited substantially by Heath (1986), who had worked with Byrne (then the first Professor of General Practice at the university of Manchester). It was a descriptive study of the consulting "styles" of general practitioners, using a methodology derived from, but distinct from, Bales' interaction process analysis (Bales 1950)(see Sacks 1992 p.28, where he criticises Bales in particular, and conventional sociology in general, for creating *a priori* categories of actors' behaviours). Byrne and Long's data was however naturally-occurring audiotaped general practice consultations, which had also become one of the sources of data for CA. My interest in the communication process was first lighted by this work, and so I owe a debt of thanks to these pioneers of general practice consultation data gathering.

Tuckett and three colleagues (Tuckett et al 1985) carried out a major study (the "Patient Project", 1977-1982, supported by the Health Education Council), which looked at audio-taped consultations involving sixteen general practitioners and 405 patients, and detailed research interviews with 328 of these. The study aimed to (a) describe what happened; (b) develop methods of assessing the process of "explaining" in the consultation, and of measuring patients' understanding of those explanations; and (c) to explore ways of integrating "lay" and "medical" frameworks into the consultation. The book reporting their findings, cleverly entitled "Meetings between experts", has been highly influential both in shaping approaches to medical education, and in informing subsequent research. It does not of course use the CA methodology, nor the principles of ethnomethodology, but the way the research interviews were constructed (sic), using the very thorough system of Brown and Harris (1978), served to ground the interview study in the experiences of members. The use of tape-recordings of consultations also brought the study closer to an ethnomethodological perspective. I have drawn on the study's findings in various ways during this work, and continue to admire it as a major contribution to our understanding of the general practice consultation.

Frankel (1989) on the other hand describes a classical CA study of North American "ambulatory care" (ie general practice), from which he has derived what he terms a "gross phase structure" for the consultation (compare with those of Byrne and Long (1976) and ten Have (1989)):

- I        Managing problems of physical co-presence
  - A Entries
  - B Greetings
- II       Diagnostic sequences - information seeking
  - A "Getting to" the reason for the visit (optional)
  - B The presenting complaint(s)
  - C History of present illness
  - D Family history, social history
- III      Physical examination
- IV      Wrap-up - information sharing
  - A Diagnoses, remedies and instructions
  - B Patient queries

V Ending the encounter

A Closings

B Departures

The differences between this "gross phase structure" and the scheme used by Byrne and Long are minor, which further endorses, in my view, the validity of their work for latter day analysts.

Kleinman, Eisenberg and Good (1978) described a number of medical cases in which the doctors had arrived at false understandings of the patients' problems, as a result of their failure to take into account the ideas behind patients' behaviours and accounts. They used the term "explanatory model" for the ways people (professionals and lay alike) construct explanations for the phenomena they observe or experience. This construct, "explanatory model", has been shown to have value in relating the activities of people, in the realm of health behaviour, to their thinking. It was influential in the studies of Tuckett et al (1985), which have in turn helped to move mainstream (eg Medical Research Council - funded) medical research in the direction of empirical and qualitative studies of interaction.

**Discourse analysis**

Having described a qualitative methodology (not CA, but a form of discourse analysis) Potter and Wetherell (1987) comment: "it is difficult to make a clear-cut distinction between the process of analysis and the process of writing up". They argue that analysts of discourse (which in the broad sense includes CA) must continually refine and revise their analytical methods throughout their work, including the writing up of the work, because the act of writing about the analysis itself extends the analysis. They also assert that "readers of discourse analytic studies need to be able, to an important extent, to perform their own evaluation of the analytic process". I take this to imply that for "qualitative" studies, the onus lies with the author to make his analysis transparent to the reader, since there is no recourse to other forms of expression, such as mathematics.

Mishler (1984) used the term "interruption analysis" to denote the way in which data is addressed, and analyzed, then the analysis exposed to the context for critical reflection, leading to a modification of the approach to the next piece of data. Thus the method itself evolves by a dialectical process during the research. In "The relationship between talk and text" (Mishler 1984 p 21-35): he criticises the "coding and counting" methods of Korsch (Korsch et al 1968), and also the transcription methods used by Byrne and Long (1976), in whose studies there is no indication of how the tape-recorded data was transcribed into text. The nature of the transcripts in their book suggests that the data was "normalized": all non-lexical speech and non-verbal features are absent, as are false-starts, repairs, and overlaps. Thus these studies (and many others in the same paradigm), are working from derived data which is incomplete.

I do not fully accept Mishler's criticisms of Byrne and Long, insofar as their data, while imperfectly transcribed, still represents an approximation of the audiotape data, to which they refer frequently in their analyses.

Another critique of CA was offered by Mehan (1991), who challenged the purist CA position that only natural speech-interaction can be the object of an analysis which truly reflects ethnomethodological principles. Whereas CA eschews the use of collateral evidence, whether of categories of social actors (gender, class, occupation) or of context (medical, legal), claiming that valid evidence for such can and therefore should be identified from members' constructions within any data corpus, Mehan argues for a "constructivist approach", represented by early Garfinkel (1967), or the more recent studies in medical settings of Frankel (1983), Mishler (1984), West (1984), and Silverman (1987). For each of these authors, social structure and social categorization are seen as *constructed by* actors in the settings observed. Data is drawn however not purely from the sequentially organized talk and interactions, but also from documentary sources, interviews, and in-situ observation. So Mehan writes:

"the constructivist line of investigation, as I see it, studies the situated artful practices of people and the ways in which these are employed to create an *objectified (my emphasis)* everyday world without losing sight of institutional and cultural context.....Furthermore, the practices are not simply an analytic device

of the researcher. they are "members' phenomena". Participants in the settings recognise the practices and orient to them during the course of interaction" (p. 75)

Thus Mehan feels able to use both members' actions from tape-recorded interactions, and a range of other materials, to construct both a macro and a micro picture of interaction. His study of a school placement meeting illustrates his thesis.

### Linguistics

An important distinction between CA and linguistics is made by Schegloff in his introduction to Vol 2 of Sacks' Lectures (op cit, xiv-xivi). Using as an example the exchange,

Emma: Are you the oldest one in the class?  
Bernice: Oh, by far.

he shows how Sacks treated the utterance "Oh, by far." as a form of "evidential" (a linguistics term), despite it not, in linguistic terms, actually being such a thing. It served as evidence for the speaker's answer because of the meaning it had for the hearer, not for its literal meaning. There are many other parallels between CA and linguistics, which this author has neither the knowledge nor the breadth of reading to address. I take this opportunity to note the closeness of the two disciplines, and the potential for collaboration in the field of medical interaction.

### Justification of an ethnomethodological approach to doctor-patient interaction

Medical practice has been the subject of sociological study since the "classics" of Parsons and Freidson (among others), raising questions about its nature, the roles of the participant categories, and its "purpose" within a wider social order (controlling, normalizing). Silverman (1987) discusses professional dominance, and its limits, in his

introduction to an analysis of doctor-patient interaction in different clinic settings (p.30). He goes on to assert that research focusing on "everyday life situations" requires that the research data should be publicly available to other researchers, in order to be re-worked by others, or by the researcher himself; and that competing explanations of the data must be taken seriously, and supported where possible by "simple counting".

"Where anecdote is coupled with mere assertion about the determinate sense to be read into a transcript, one is left with polemic rather than analysis" (op. cit. p.33).

The issue of the "public availability" of data raises an ethical question about the confidentiality of the material, and the nature of the consent given by the patients at the time of the recording. It is this rather than any technical difficulty in reproducing recorded data that makes it necessary to present anonymized material (see West 1984). Heath (1986) discussed this point with reference to pictures illustrating movement, and concluded that line drawings adequately conveyed the necessary information, without revealing the identities of individuals. In the same way, identifying utterances, such as full names, have been changed, in transcripts which in all other respects fully represent the interactions. It has become conventional in CA research to publish as much transcribed data as possible, and to make full transcripts available to the research community, at meetings, or on request. However, as West observed, citing Sacks, real names can be critical to the understanding of an utterance, so analysts need to be aware of this. This issue is considered further in Chapter 2.

### **The "sacredness" of patients**

Sacks (1992) (Lecture 4, Fall 1964) quotes Freud as saying "now let's treat patients as sacred phenomena", (but I cannot substantiate the quotation from its source). Sacks used it to draw a parallel between studying "a line" of everyday speech, and

"the way that biblical critics have studied the Bible, where the fact that you were looking at one line wouldn't mean that you could only write a page on it. You

could write 100 pages. You could spend your life studying it". (Sacks 1992 Vol 1 p.28).

However, the idea of the "sacredness of the patient" is worth borrowing here to look at the notion of the "patient-centred clinical method" of Levenstein et al (1986). Here the authors describe a style of consulting which emphasises the patient's centrality, by encouraging doctors to give attention to the exact words, or even to the hidden "cues" within what patients are saying. They do not use the terminology of CA, nor do they transcribe consultations in the same detail, but they do recognise many of the phenomena that Sacks and his successors have described. Osler (1849-1919) is credited with the dictum "Listen to the patient: he is telling you the diagnosis", by which he meant that much of what a doctor need to know in order to understand the nature of a patient's problem can be obtained by careful listening, rather than by focused questioning, or by examination. This idea, although paid lip-service in medical education, has observably been lost in medical practice.

#### A biographical aside

Sacks, in Lecture 4 (op.cit, p.27) stated "what I do.....stands in close parallel to classical naturalistic biology or zoology". I was struck by the irony of my recall that in 1967, when Sacks was lecturing in Los Angeles, I was attending a post-graduate course in San Francisco, during which I carried out some naturalistic studies of the neurophysiology of the cat brain, which led to the publication of a short report (a "letter") in the science journal *Nature* (Campion, Biscoe, Samson 1968). That study described, in some detail, the naturally occurring electrical impulses that were present in the brain stem of the cat, and which were associated with breathing. The relationship between the brain stem impulses and those recorded from the phrenic nerve (the nerve supplying the muscles of breathing) was described, and interpreted, and the data was reproduced in the article.

The parallel to which Sacks referred in his lecture is here displayed. The natural scientists, possessed of a technique that allowed the recording of electrical impulses within individual brain cells, used that technique to explore the detailed phenomena



found in that territory, relating the observations to others in the same field, and to phenomena in the world of everyday life, in this case, breathing.

### Qualitative versus quantitative sociology

Wilson (1987) addresses the "qualitative-quantitative" controversy in his essay on the place of mathematical models in social research. "Extensionalism", the belief that *any* expression, including "intentional idioms" (terms like believe, want), can be substituted for by any other expression with which it shares logical "truth", seems to be the rational basis for the scientific drive to eliminate indexical expressions. Extensionalism assumes that the only alternative to standard logic is ideology, or some form of non-rational imagery such as poetry or myth.

Wilson goes on to refute the validity of this approach on logical grounds: there is a logical flaw because:

"in order to explain standard logic we need a meta-language; and if the meta-language is also a version of standard logic, as required by the doctrine of extensionalism, we need a meta-language to explain the meta-language, and so on. .... We have then a paradox: extensionalism fails the extensionalist test for rational discourse." (op. cit. p.392)

This is not to rule out any use of mathematics in the study of the social world, but only to see its limitations. The descriptions produced by people of their own activities cannot be relegated to the status of epiphenomena, and ignored (as conventional constructivist sociology has done), but within ethnomethodology and CA can be elevated to the high status of being central to the understanding of how people "do being ordinary".

**Ethnomethodology as an "educational" tool**

It follows that the results of a conversation analysis should be capable of being made comprehensible to a reader who is also a member of the social group being observed<sup>3</sup>. The implication is that certain aspects of human social activity are not, in the natural way of life, consciously perceived by members, but can be so perceived if brought into their awareness by some process. The processes of recording and transcribing, then collating and explicating data of such an everyday activity (for doctors) as consulting with patients, might be expected to increase those doctors' awareness of their own behaviour. Self-awareness is a critical, and probably necessary, component of learning, (Schon 1987), although not in itself a sufficient cause of change. But the neutral, member-derived explanations of phenomena described by conversation analysis may be sufficient causes of change in a member who becomes aware of them.

Medical education seeks to enable students to acquire such knowledge, attitudes, and the skills of knowledge handling, interpersonal communication, and physical examination, which will allow them to practice as junior ("embryo") doctors, while continuing the learning process through the years towards "accreditation" as an independent practitioner or specialist. "Sociology" has been a prescribed part of the undergraduate curriculum for at least ten years, but its purpose has not been comprehensively expounded. Traditional medical sociology teaching comprises what would be better termed social medicine: the extent of illness in the community, or the relationship between poverty and health. Other strands commonly include the "sociology of professions", "deviance", and "illness behaviour". Only in curricula where communication is seen as related to interactional theory, rather than behavioural theories, is the sociology of interaction discussed. Here, insights from CA can be set alongside other material. The potential for CA-based expositions as a vehicle for teaching "sociology", if by that we mean the study of the organisation of everyday life, has yet to be developed. My thesis would be that material of the sort described here is ideal for this purpose.

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<sup>3</sup>See the section "Notes on the methodology prompted by presenting a piece of ethnomethodological research to an audience of academic general practitioners", in Ch. 2

This is not to argue that sociological work of traditions other than CA is not accessible to members, but it is argued that members who read a sociological work from a paradigm other than ethnomethodology might need at least some prior understanding of the concepts and nomenclature employed by that "sociology". For such work to be educational, some prior learning within the discipline "sociology" would have to be achieved. This could be seen as a disadvantage for groups, such as health professionals, whose time for formal study may be limited. My argument is that ethnomethodological studies may be more efficient ways of conveying self-awareness to people who need, for their professional development, to learn to change their behaviour, than studies grounded in other theoretical frameworks.

### Conclusion

In my title *"On structures in medical interactions"* I have alluded both to Talcott Parsons' *"The Structure of Social Action"* (1968), and to the major CA collection edited by Atkinson and Heritage (1984), *"Structures of Social Action"*. I do not claim to have described or explained *all* structures in medical interaction, nor do I argue that medical interaction is fundamentally different from other interactions. Rather the reverse: because so much of what CA research so far has shown to be the case in everyday conversations is also true of talk in "institutional" settings, a thesis based entirely on medical interactions can be relevant to other sorts of interactions.

## **CHAPTER 2: METHODS**

**"A program of work undertaken several years ago to explore the possibility of achieving a naturalistic observational discipline that could deal with the details of social action(s) rigorously, empirically, and formally."  
(Schegloff and Sacks 1973)**

### **Origin of data in this study**

This thesis is based on material collected since 1987, initially as part of a project organised by the author to make a series of video-tapes for teaching, which would illustrate the findings of Tuckett et al (1985). That project was described in an article for general practitioners, (Campion 1987) and resulted in the publication of a series of training video-tapes (Campion 1988). The aim was to record a series of "typical" consultations between general practitioners and their patients, but to enhance these by recorded interviews with the patients, both before and after the consultations.

### **Selection of practices for data collection**

Four practices were selected by two criteria: (i) that they had already had experience of video-recording consultations (and so would be familiar with the technical and organisational aspects of making the recordings); and (ii) that they were in contrasting socio-economic settings.

I selected one practice from the city of Liverpool, another from one of its suburbs (Waterloo). A third came from a mixed community on the Wirral, and the fourth from

Basildon in Essex, a relatively prosperous new town outside London. Within each practice, video-recordings were made of surgeries conducted by each doctor in the practice, including one "trainee" (a qualified doctor in the course of a three-year vocational training programme including one year in general practice). Recordings were made of two doctors in the Liverpool practice, three, including the trainee, in Waterloo, two in Wirral, and three in Basildon. A total of 77 consultations were recorded at this stage (other recordings have since been added to the collection, see below).

### **Selection of patients**

There were two ways whereby patients who intended to consult with a doctor were not included in the recorded data. In each setting, patients were informed beforehand by a member of the practice staff, usually a receptionist at the time of booking an appointment, that the particular surgery session was to be recorded, and a number, (unknown), chose to make their appointment with a different doctor on that occasion. Those who attended a session were then informed again that recording was taking place, and invited to give consent. The receptionists emphasised the patient's freedom to decline, and also to withdraw consent after the consultation. A written consent form was signed by each patient on each occasion (Appendix 3).

Further data has been acquired since 1987 by regular recordings of surgeries at the general practice where I conduct my own clinical work, The Elms Medical Centre, Dingle, Liverpool 8. Six principals and four trainees have been recorded during normal surgeries. The refusal rate here is very low, except for the surgeries conducted by the two female partners, who see a high proportion of older women with gynaecological problems.

Therefore I can make no claim that the selection of patients was random: it was clearly biased by the selection processes. I will, however, argue that this does not invalidate the data as material suitable for interaction analysis.

### **Ethical considerations**

#### **(a) Consent.**

Video-recording is a potential intrusion into the privacy of the consultation (Spence 1960), and therefore should never take place without fully informed consent from the patient(s). In the original project, where the recordings were being made for a commercial production, albeit only for medical educational purposes, we ensured that a detailed explanation was given, and that written consent was obtained both before and after the recording. Subsequent recordings, made in the author's own practice, have been covered by the same procedures. Consent forms are reproduced in Appendix 3.

#### **(b) Security.**

The recordings constitute highly sensitive personal information, more so than written medical records, or computer records, and deserve the highest care to safeguard them from accidental or deliberate loss or theft. The tapes are kept in secure cabinets in a locked office in the University.

### **Justification for using recorded data**

Audio- or video-recording is necessary because (1) pre-selection of topics is not part of the research strategy, and (2) the phenomena are so intricate and complex and have such restricted temporal and spatial features that no observational system relying on the ordinary senses operating in "real time" is capable of capturing them in all their constitutive details. (Psathas 1990b p.5) It has become commonplace in medical education to video-record consultations for use in training sessions (Pendleton et al 1984). This has had the effect of making it a more "routine" activity for many doctors, thereby reducing any biasing effect of the recording on the interaction.

### **Validity of video-recorded consultation data**

This question of whether the process of recording affects the events being recorded was addressed by Heath (1986, in notes to Ch.1)), but only with anecdotal evidence. Pringle and Stewart-Evans (1990) tested the hypothesis by experiment. They compared doctors'

behaviour in general practice consultations under two conditions: knowing that the event was being video-recorded, and not knowing. They circumvented the ethical problem of the latter state by obtaining consent to record at any time during a month, and arranging the technology such that the doctors could not tell whether it was operating or not. Their study showed no differences in the doctors' use of time during the consultations, between consultations when they knew they were being recorded, and those when they did not. They compared overall length, numbers of problems dealt with, and a range of verbal and physical activities by both doctor and patient (such as posture, questioning, giving medical information, and silence). They noted that their results were only strictly valid for the four doctors they studied, but since these comprised two who were used to being video-recorded and two who were not, and there was no difference between these two pairs in the results, they concluded, "within these constraints it is possible to conclude that the anxiety often expressed by doctors - the 'I won't behave normally if a camera is there' - is unfounded."

### **The effect of the recording process on the consultation**

**(Data: Transcript 2.1, Appendix 2)**

It will be helpful at this point to consider a piece of data, partly to illustrate the previous sections, and partly to allow reflection on the data collection process itself. Transcript 2.1 is an extract from a consultation involving the author<sup>4</sup> and a patient who had attended complaining of dizzy spells. Having wondered whether her symptoms were connected with her work, I spent some time exploring what she was doing at the present (lines 1-25), during which she said (l.11) "it was a lot to take in at once", and (l.13-15) "that's what I found, you know, most difficult, remembering what the keys were for". She elaborated this, after my "mhmm", and a 2.2 second pause (line 18), with:

20P     and wa- you know what er programmes they were all for=  
 21P     =and w- what to put in and what to delete and what you know an=  
 22P     =I thought hhgh  
                                   [  
 23D                                °yes

---

<sup>4</sup> While this datum is drawn from a corpus of recordings of consultations carried out by the author, that has not been the rule for this study, where, for reasons discussed later, I largely separated my "medical role from my analyst role.

After this almost "explosive" burst of distress, she added:

24P and it was all in me head like but I dont know whether thats got anything=  
25P to do with it or not I- .hhhh

and I chose to try another track, with:

26D well lets look at any other possibilities?  
27D ha- have you been quite healthy.

Describing a recent cold, she said:

34P but I mean I do suffer with catarrh but not dizzy spells.

The next three lines are of interest, as after a short, 0.2 second gap, I say with emphasis, and with a lengthened vowel, "NO:", and take an inbreath (".hhhh"). Her next utterance is spoken as she looks briefly at the camera,

36P I bet you'll have a good laugh over this with that camera dont yer? hhchou hhh

The considerable perturbations and hesitations that follow indicate my discomfort at being challenged in this way! It takes from line 37 to line 52 before I return to the previous topic, and the consultation followed an unremarkable course to its end.

I draw attention to this datum because of its exceptional nature: in some 50 hours of recordings there has been only one other instance of the camera even being mentioned (transcribed at 4.6). The impression from watching these consultations (also Heath 1986), together with the evidence from more formal research studies (Pringle and Stuart-Evans 1990), strongly supports the view that the camera has a very small effect, if any, on the interactions.

### Technical aspects of data collection

Technical details of the video-recording are not particularly relevant to this thesis, as they have been described elsewhere (see for example, Heath 1986), but some observations can be made. I found that modern, domestic camcorders give barely



adequate sound from their built-in microphones, and that better sound can be achieved with separate microphones placed on, or suspended over the desk. The choice of tape format was governed by the equipment available to me: 8mm format was used for some recordings, but VHS for the majority: copies of extracts were made onto VHS.

### Transcribing the data

Appendix 1 contains an account of both the transcription conventions used in this thesis, and also the rationale for using them. Gail Jefferson, Sacks' former assistant and later collaborator, was responsible for developing this system, which has evolved as CA has expanded. Zimmerman (1988, p.412-415) gives a good account of the principles underlying the choice of level of detail for transcription. Essentially, a transcript represents those components of the data itself that are at the time being addressed and analyzed: it can never be the data. One important technical point which has arisen since the conventions were developed by Jefferson and colleagues in the 1960's and early 70's is the advent of word-processing, and the ready availability of computer-based text handling. While the original transcriptions (and I am told this is still done) were typed on a typewriter, when the relationships between symbols are fixed on the page, it is normal now to use word processing. The fact that a computer stores textual information separately from the print format means that the spatial relationship between words and symbols on the computer screen may not remain when the text is printed out<sup>5</sup>. Word-processing programmes offering "What you see is what you get" are better than earlier ones, but still cause problems when the type face is "proportionally spaced". The solution is to use, for data, a type face that is not proportionally spaced, of which "Courier" is the commonest. In my data presentation here I have used a font called "Line Printer 16.67 cpi" (characters per inch), but any non-proportionally spaced font can be used. It allows concordance between letters, spaces, and symbols such as hyphens and dashes, all of which occupy the same length of space in a line.

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<sup>5</sup> This is particularly critical in the transcribing of overlaps, and the placing of square brackets.

## Analysis

### (a) application of Conversation Analysis theory to medical data

A parallel may be drawn between Garfinkel's categorization of accounts as either "indexical" or "objective" (Filmer 1972) and the distinction between "lay" and "medical" in any discussion of health or illness. Medical ("objective") accounts of illness are couched in "scientific" terms: symptoms are given labels such as "dyspnoea", "stridor", "dysphagia"<sup>6</sup>; illnesses are labelled with "diagnoses", for which professionals recognise common definitions (for a historical perspective on diagnosis, see Parkinson (1945), Cassidy (1946), and Major (1945)). By contrast, laymen describe illness in terms of individual ("indexical") experiences, their own or those of others, basing these expressions on commonly held ("indexical") constructs (Kleinman et al 1978, Helman 1990).

### (b) The process of Conversation Analysis

The "data" comprises the recordings, or rather, the events which the recordings represent. These are real, everyday happenings, "captured" by an "eavesdropping" technology which in media language would be termed "fly-on-the-wall" recording.

My initial approach to the data was guided by the work of Heath (1986), and by discussions with him and other sociologists, notably Goodwin (at a seminar at Surrey University), and Greatbach. The literature of CA has been accumulating throughout the period covered by this thesis, such that early encounters with Sacks' writing were through photocopies of unpublished mimeos, and only in 1992 were the full collected and edited Lectures finally published (Sacks 1992). The most succinct and thorough account of method appears in Psathas (1990b), from which I draw the following section.

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<sup>6</sup> Medical terminology in the United Kingdom included many such Greek and Latin expressions until recently, and some, such as these, persist. Dutch medical writing still uses Latin terms for many diagnostic labels.

"The first stage of such research can be characterized as "unmotivated looking". This is a term which is intended to imply that the investigator is "open" to discovering phenomena, rather than searching for instances of already identified and described phenomena, or for some theoretically preformulated conceptualization of what the phenomenon should look like." (op. cit. p.3 and footnote).

Psathas notes, and I fully concur, that written consent from all involved is conventional, but I would prefer "essential" (see Appendix 3). Privacy is accorded by the alteration of names and time and place details, a practice which I have adopted in the transcripts in this thesis. One reason for this, other than the preservation of privacy, is that the studies are in no way related to who the participants are, but rather to the organizational aspects of the interactions, hence there is no need to identify the participants.

The most systematic early paper on CA is probably Sacks, Schegloff and Jefferson (1974) "A simplest systematic for the organization of turn-taking for conversation". It sets out their model of a turn-taking system, comprising a turn-constructual component (sentence, clause, phrase, word), and a turn-allocation component, whether selected by previous speaker, or self-selected. They described the "rules" for turn allocation, and related these to the observed "facts" of conversations, as they had recorded, and transcribed them. I do not propose to reproduce these here, but have referred to them in my analyses (see p.41).

Another early exponent of CA, Schenkein, (1978) listed the attributes of the "analytic mentality of ethnomethodology" as:

1. utilizing a corpus of data consisting of naturally-occurring interactions;
2. developing analyses grounded in the details of actual occurrences;
3. viewing the study of conversation as "essentially interactional activity";
4. focusing on "the sequential emergence of turn-by-turn talk";
5. using a "standardized transcription notation system which captures the details of conversational production";
6. sharing a commitment to a "non-intuitive" (ie a data-based rather than a constructed, recalled, or imagined) description of the interactional phenomena;

7. presenting findings which describe the "organization and artfulness of natural conversation";
8. attempting to develop conceptual schemas to connect the particularities of contexts studied with the abstract culture."

(cited in Psathas 1990b, p.2)

Data is viewed repeatedly, and transcripts made to allow for the possibility of other researchers noticing, collecting, and studying the same or related phenomena. Psathas adds,

"A move from the logic of discovery to that of verification is made possible through such data collections." (op. cit. p.5)

"What are interactional phenomena?" In one sense this question cannot be answered concretely, as to do so would limit something which is conceptually limitless (see my comment on Garfinkel and Sacks (1970) on p, 9). In practice they are utterances and activities, including gross bodily movements, described initially in gross terms such as might be used by a co-participant, then in detail, using the notation system which is flexible enough to adapt to new uses.

"We will refine our description and make every effort to use only those terms which members might or could use".(op. cit. p.6)

Conversation analysis, in contrast with "constructive" behavioural sciences, makes no assumptions about:

- "- the speaker's intentions, purposes or motives
  - the speaker's ideas, or thoughts or cognitions or understandings
  - the speaker's feelings, emotions or moods
- except as, and insofar as these matters can be "interpreted" by the hearer in the course of the speaker's actual utterance and co-occurring bodily movements."  
(op. cit.p.7)

"Constructive analytic interpretations" (i.e. categorising members' attitudes, or levels of motivation, or such constructs as mood) are not part of CA, not because these may not be valid interpretations of the data, but because the underlying methodology of CA, grounded as it is in phenomenology, sets the prime agenda as the discovery of phenomena, rather than the construction, by the investigator, of reality. If inferences are drawn which appear to use constructs, these must derive from the talk and actions of the members themselves.

"Our claim about what the phenomenon is must be based on the phenomenon itself - what any one of us can discover and "see" if we also are brought to a point where we can "see" the same phenomenon."

Wilson (1991) adds:

"parties to a concrete interaction must address the question of who they relevantly are and what they are about on a given occasion (citing Sacks, 1972). This is an irremediable circumstance facing the participants, and the analyst cannot settle the issue on their behalf by invoking some theoretical scheme or interpretation of the situation. Instead the relevance of particular social-structural categories on a given occasion consists in the way the participants in the interaction display to one another their orientations to those categories in a manner that is consequential for their interaction. this principle of relevance is fundamental to ethnomethodology and conversation analysis."

This position creates further need for the data to be available in the form in which it was recorded, and open to review by peers. Transcription, insofar as it reproduces the data, stands as a proxy for the data. For the same reasons, reference to the published literature of CA can legitimately be made provided there is data in that literature to substantiate a claim, and ideally the data should be reproduced in the citation.

Psathas goes on to describe the characteristics of an "interactional phenomenon":

- It has a visual and/or auditory and/or tactual and/or kinaesthetic appearance for the participants in the actual course of the interaction;

- It has a spatio-temporal appearance which includes speech, movements, relationships between these two, and a "situated character.

The phenomena themselves may be noticed by participants, or if not noticed, then available, and observably oriented to and situated in the spatio-temporal organization of the interaction.

The descriptions of a phenomenon may include details of: its audio-spatio-temporal course; its constitutional elements; its pattern rhythm, synchrony, coordination, flow; its sequential properties within and between participants; the between-ness of its production; and any simultaneous synchrony of actions.

Anderson (1989) working with dentist-patient encounters, observes that while traditional sociology imposes concepts on the interaction, CA is *more rigorous and empirical* in describing these encounters in "a way which is sensitive to their emergent qualities as practical, everyday accomplishments by their participants".(p.81) He develops the notion of an "activity system" by analogy with Sacks, Schegloff, and Jefferson's "speech exchange system", but quoting Goffman who coined the term without then using it in an empirical and exploratory way.

A model activity system is offered, in which the dentist routinely approaches a patient for a mouth and teeth inspection, called, reasonably, an "inspection sequence":

- 1 Next-task specification
- 2 Pause
- 3 Task-bound request
- 4 (performance)
- 5 Open or specified assessment

The pause (stage 2) appears to act as a non-verbal "second pair part", in the sequential organisation of these encounters. Anderson's paper shows the application of CA methodology to a very particular context, but without losing the essential qualities of CA.

## Relevance

Given such a comprehensive agenda, which could become limitless in its pursuit of detail, another question of "relevance" has to be addressed. Wilson (1991) in his essay on "Social Structure and the Sequential Organisation of Interaction", takes a step back from the details of CA to consider how these details relate to "social structure", a theme that has become central to CA in the past 10 years (see Atkinson and Heritage 1984, Button and Lee 1987, Boden and Zimmerman 1991, for just three collections of CA addressing this issue). His argument is that since the phenomena elicited and explicated by CA are so widespread, there is a "generality" within interaction that at one level can "explain" interactions across contexts. But at another level, the individual relevance of each context creates different meanings every time, so "we must necessarily make our concern for orientation to social-structural context explicit" (op. cit. p.36). Thus CA can reasonably be applied to any interaction, in any context, provided that the relevance of the context for the participants is elicited from the data.

The following account is not available for analysis in proper CA fashion, because it was not recorded. However, it serves as an illustration of the relevance of the questions raised by CA to medical work. The account was given to me by a nurse working in a general practice (a "practice nurse"), concerning her encounter with a patient. The context was that this nurse had been trained to manage patients with bronchial asthma, but the doctors with whom (and for whom) she worked did not recognise her expertise, but preferred to treat patients themselves. The patient in question had been receiving regular prescriptions, without seeing a doctor, for an asthma-preventing drug. He had come to the surgery on this occasion to see a doctor because he had developed a cough, following a cold. The doctor had previously prescribed an antibiotic for this cold, but the cough had persisted, hence the return visit. After he had seen the doctor, he was referred to the nurse by the receptionist, who knew that the nurse was interested in managing asthma patients, and recognised the drug that was being prescribed regularly as an asthma drug.

When the man was interviewed by the nurse, she asked him whether he was having any trouble from his asthma. He replied that he was not. She asked, "do you get any cough at night?" to which he replied "No". Then she asked, "Why did you come to the doctor today?", to which the reply was "because of the bad cough at night". Confused, she asked

him why he had just told her that he did not get a cough at night, but then said that he did. He explained that the cough he came to the doctor about was due to the cold, and was nothing to do with his asthma, which gave him no problems, since he took the preventive drug regularly.

The nurse thought it very likely that the cough was indeed caused by the asthma, which is known to be made worse by viruses such as the common cold. She was particularly impressed by this misunderstanding, since it was associated with the patient not receiving the more usual treatment for asthma attacks, which would almost certainly have relieved his cough.

Sacks (1992, vol 1, p.23) refers to members' "common knowledge" which enables them to share ideas of classes, members of classes, and to be able to place objects in classes. This patient held two classes of disease, "cold", and "asthma", and placed his cough in one but not in the other. Other patients, who have learned more about asthma, share a knowledge of classes which corresponds more to that of the nurse than that of this patient. It is not at all clear however whether doctors share the same "common knowledge", since many, including the one in this case, appear to share the classification of this patient. CA would explore the effect of these members' respective understandings on their interaction, and would seek to explain why the same word appeared to mean different things in two adjacent utterances.

Kleinman (1978) used the term "explanatory model" for the ideas held by people about their experiences of illness, which is not unlike the "common knowledge" of Sacks. Medical interactions are full of instances of "categorization" or classifying, much of which is done by members, in the ordinary course of living, they are "ordinary" categories, like colds, coughs, symptoms, viruses. CA above all is concerned to explicate such everyday reasoning, but in so doing, sheds important light on the patients' perspective, which many doctors seem to lack!

### **Selection of topics for study**

It is reasonable to regard the video-taped consultations as close representations of what actually happened, the "concrete event" (Cicourel 1973). Conversation analysis seeks to



find within such data meanings and explanations behind members' actions. Which actions are made the subject of analysis is arbitrary, and early CA studies are notable for the very "ordinariness" of their subject matter. Thus Sacks explained in an early lecture:

"Now people often ask me why I choose the particular data I choose. Is it some problem that I have in mind that caused me to pick this corpus or this segment? And I am insistent that I just happened to have it, it became fascinating, and I spent some time at it. Furthermore, it is not that I attack any piece of data I happen to have according to some problems I bring to it. When we start out with a piece of data, the question of what we are going to end up with, what kind of findings it will give, should not be a consideration. We sit down with a piece of data, make a bunch of observations, and see where they will go." (Sacks 1984, derived from two 1967 lectures).

Sacks appears here to imply that he exercised no control over the direction of his research, so wide was the potential agenda, and so general the methodology that he was creating. Later workers have had no difficulty in specifying the context of their work as, for example, Zimmerman and Boden (1991) show in their introduction to a collection of studies ranging through medical consultations, school entrance procedures, broadcast news interviews, and emergency telephone calls.

I have chosen to examine actions which I have found interesting, either from my reading of the literature within the tradition of CA ("facilitation", ch.6, and "questions and rejections", ch. 7), or of other sociological literature ("We", ch. 8, and "the use of time", ch.3), or from an interest, not unrelated to my *alter ego*, in the process of general practice ("the use of medical records", ch. 4, "treatment talk", ch.5). I chose to explore the construction of "we" talk by doctors, after reading Spiegelberg's (1973) paper, which had no particular "medical" relevance, but which elicited strong resonances in my own practice of observing my own and other medical consultations. The topic of treatment, and in particular the way doctors and patients construct their talk around it, was stimulated by the awareness that this component of the consultation was probably the least well understood by patients (Tuckett et al 1985, Byrne and Long 1976).

Tuckett's study also prompted the exploration of patients' rejecting doctors' ideas. Tuckett *et al* showed that doctors often reject patients' ideas, either overtly, by cutting off (interrupting), or covertly, by ignoring them. In the course of "unmotivated looking" (Psathas 1990b, *op. cit.* p.3) I found a set of cases where patients overtly counter or challenge doctors' arguments, which, according to Tuckett would represent the ultimate in "conversational" interaction, in which the asymmetry of the doctor-patient relationship has been to a large extent equalized.

"Time" has become a subject of great interest among researchers in general practice (Ridsdale *et al* 1989, Morrell *et al* 1988, Howie *et al* 1989). It seemed appropriate therefore to apply the techniques of conversation analysis to this issue, and ask how doctors, and patients, used the known methods of managing interaction to deal with time constraints. Clearly this part of the data was not discovered without motivation: how justified it is to seek for phenomena that relate to a particular question is debatable. If the broad area is pre-determined, the nature of the phenomena clearly cannot be. I believe such an approach is defensible.

The use of records (ie case notes) is almost universal in western medical practice, although very little sociological study has been addressed to exploring their use<sup>7</sup>. Now that computerization has reached general practice records, to the extent that in 1990 some 50% of British general practices used a computer for some patient records, and some 30% of these were using the computer on the desk during the consultation, it became important to develop an understanding of how the record was used in medical interactions, and how introducing a computer in place of or in addition to the paper record would affect this. Work is in progress, not within the scope of this thesis (Greatbach *et al*, 1993) on this theme, but the study reported here has relevance to the general issue of records interacting with participants in any interview situation.

My dual role, as a practising doctor in general practice, and as an academic with an interest in conversation analysis, has made this study doubly interesting. The relatively "strict" rules of CA, requiring first a detailed transcription of video data without making any assessment or judgement of it, and then a dispassionate, unmotivated looking at the

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<sup>7</sup>An exception is Heath (1986), who devotes a postscript to the subject of records, pp. 153-165, and computer use (pp. 165-173).

data for evidence of order *as defined by the members* has made it possible to do the analysis without, I hope, being biased by the unavoidable fact that I am a member of the medical profession! As it happens I am also a member of the class "patients", by virtue of several (not life-threatening) medical problems. My principal membership is however of the class "people", and it is as a member of society that I most appreciate the opportunity of "doing ethnomethodology". The presence in Appendix 2 of full transcripts of all the data to which I refer in this thesis preserves the conversation analytic principle that data must be accessible to others for confirmation or refutation. It is for this reason that I include here the following account of the way some CA results were received by an audience of medical practitioners.

**Reflections on the methodology, prompted by presenting a piece of ethnomethodological research to an audience of academic general practitioners.**

If one aim of sociology is to "make sense of" the way human activity exists (this expression avoiding for the time being issues of how that existence is perceived), then the output of sociology ought, sometimes, to be intelligible to participants in that activity. I use the qualifier "sometimes", because, for internal use by the practitioners of "sociology", it may at other times be appropriate to present ideas, findings, and interpretations in ways that non-practitioners, by being unaware of the frames of reference, might not find accessible. But for the discipline to be consistent with this aim, then sometimes its methods, subjects, and conclusions, ought to be accessible, and intelligible to members of the society it seeks to study.

At the same time, because it has constituted itself as an academic discipline, with all the paraphernalia which that implies, sociology needs to display appropriate rigour, in its approach to both empirical and theoretical study (Silverman 1993). When I presented a conversation analysis study (Greatbach et al 1993) to an audience composed largely of medical practitioners, whose research paradigms lay within a positivistic framework (as witnessed by the majority of the scientific papers presented at the meeting), their responses challenged (but did not overturn) these assertions. The extent of the acceptance of a piece of conversation analysis might point to the acceptability of the methodology by the society to which it was applied. The study explored the detailed

interactions between doctors and patients in the setting of general practice: the working context of the academics present at the meeting.

Understanding was evident at several levels: the analysis of general practice consultations has been carried out in the UK for the past twenty years, and several studies have become very well known (Byrne and Long 1976; Tuckett et al 1985). The study could comfortably be set in this context in terms of its broad purpose of exploring further the activity of "the consultation". Secondly, the method of data collection, video-recording, was well known to this group, through its wide use as a teaching tool (Pendleton et al 1984). However, the audience was quite unfamiliar with the actual methodology of conversation analysis, which therefore required to be justified.

Terms such as the "concreteness" of the data (Cicourel 1973), or the "reflexivity" and "indexicality" of talk (Garfinkel 1967) would have been totally unintelligible, and counter-productive to understanding. On the other hand, the principle that the subject matter for study was essentially the "everyday activities of members", obtained in as naturalistic way as possible, was both comprehensible, and acceptable. However, the assertion that the analysis depends on members' "taken-for-granted" assumptions, which are derived from the data itself (Sacks 1984), was probably not immediately shared by this audience. It required the development of the paper itself to begin to convey these ideas.

Data, in the form of a series of video-tape fragments from the same phase of each consultation (the initiation of a prescription), was shown, more than once, to emphasise the "phenomena" under discussion. The term "phenomenon" was used to emphasise the neutral stance of the researcher: the interaction was being considered from the point of view of the actors, or participants. The researcher's task was to identify these points of view, from the data itself, and to make sense of the interaction for himself, for other researchers, and, as I have already argued, sometimes for the members involved.

As the data was shown, and interpretations offered, the opportunity was there for the audience of members to make their views known to the researcher. (With hindsight it might have been better to have recorded the discussion on tape.) The major issue, that what was being described was what the other members of the group (of general practitioners) agreed was happening, seemed non-problematic. Members accepted that the description of the relationship of the patients' speech to a sequence of computer

keystrokes was "true". The method allowed the clear presentation of this sort of data, supplemented by transcripts. In this, the audience and the researchers were all "members" of society, and as such shared understanding of the meaning of speech and action in the commonplace setting of a doctor-patient interaction (ten Have 1989). There was shared understanding of the nature of the interaction (initiating a prescription for a medicine), of the identities of each participant, and in the cases discussed, of the broad implications of placing a computer on the doctor's desk. Discussion focused on how other doctors might use the computer, depending on their experience with it, rather than how different patients might respond to the cues or phenomena being presented to them by the doctor in the data. Since both doctor and patient were of equal relevance to the analysis, and since the audience identified more closely with the former, this form of comment was valid, but incomplete.

Beyond the description of what happened, the paper set out to characterise a process which we labelled "in-situ socialization", a term also used by ten Have (1989) to describe his analysis of the ordering of general practice consultations. This concept was readily accepted by the discussants in the audience, who were able to use the term to describe both their own experiences, and those described in the paper. This seemed important, since the idea of "in-situ" implies no external influence on the process. If a social learning process occurs in a particular setting, then its description and explanation should also take place in that setting, without reference to external norms. This is the characteristic of ethnomethodology which distinguishes it from other forms of sociological enquiry.

When the researcher sought to explain the reason for the sequence, in terms of a range of antecedent events, there was more scepticism: by presenting only four or five examples of related phenomena the researcher could not justify making a "global" statement about patients and doctors. The audience offered local explanations for the phenomena, in the light of their own experiences as actors in the same settings. The weakness of this approach lay only in its failure to give evidence of generalisability. Such a weakness can be overcome by broadening the sources of data, increasing the sampling from the data, but ultimately only by examining data from the member concerned.

Similarly, when a much-shortened version of chapter 8 of this thesis ("On the right to say 'we'") was published in a journal dealing with the continuing education of doctors

(Campion 1990), in the same way as the conference paper was criticised from an "inside" position, so this paper drew correspondence (Graham 1990) raising an alternative explanation of the phenomenon (the use of "we" by individual doctors) from the position of members (doctors). The correspondent's arguments were valid *for him*, but not for the data, unless he had considered the whole data set.

### **Conclusion**

Conversation analysis has become, in the course of twenty years, a recognised analytic discipline. Its "beauty" lies in its reflexivity, its insistence on making its workings transparent, "observable". Practical and ethical constraints prevent the inclusion of the video material in this thesis, although technically this would be relatively easy with CD-rom technology. The material is however available for consultation by *bona-fide* researchers, through the author.

## CHAPTER 3: TIME IN THE CONSULTATION

"In the short time they are together (six minutes on the average) what is the doctor able to learn about his patient, and what has the patient been able to convey about himself? What can be achieved during such fleeting episodes?" (Norell 1973)

### Introduction

"The problem of pressure of time has therefore become a major characteristic of modern general practice and indeed, as Huntington has suggested, has produced a particular time orientation amongst general practitioners which differs from other occupational groups in the health care system." (Armstrong, 1985).

Evidence to support this view is found in recent studies of general practitioner workload (Wilkin and Metcalfe 1984, Roland et al 1986, Butler and Calnan 1987, Morrell et al 1986, Ridsdale et al 1989, Howie et al 1989). These all focused on doctors' use of time, and in the study by Butler and Calnan, on the doctors' beliefs about time constraint. In my own (recorded) interviews with patients, made before they saw their doctor (Campion 1990), several expressed views about the constraint of time on the way in which they felt able to express their problems, and the guilt they felt in taking up time needed by others. Horobin and McIntosh (1983) argued that "this tyranny of time is an oversimplification". Drawing on the medical "health service" literature, and on their own interviews with 50 general practitioners, they claim that there are several components to the concept of "time" for GPs, and that doctors talk about time as a way of making sense of the pressures they experience in their work, that "time has been a dominant theme in general practitioners' talk about their work". This is a "constructionist" study, in that the authors apply their own categories to the phenomena

they describe, but it serves as a context within which to examine consultations for the sequential in-situ organization of endings.

No study of the endings of encounters could begin without a consideration of "Opening up closings" (Schegloff and Sacks 1973). Although this seminal paper achieved far more than its title suggested, by launching the "adjacency pair" theory, it does show how early CA work addressed the problem of endings.

"Turn taking machinery includes as one component a set of procedures for organizing the selection of "next speakers", and as another a set of procedures for locating the occasions on which transition to a next speaker may or should occur" (p.293)

Their study of telephone conversations led to the formulation of the "rules" of turn-taking, which are now taken-for-granted in CA, but which marked the beginning of the understanding of the in-situ organization of talk. The first "problem" for Schegloff and Sacks was "how to organise the simultaneous arrival of the co-conversationalists at a point where one speaker's completion will not occasion another speaker's talk, and that will not be heard as some speaker's silence." (p.295) This led to the formulation that "first speaker selects next", and that one person, and not more than one, speaks at a time. They noted that silence broke the "rule" of turns in conversation, that at least..... one at a time speaks. This observation may particularly interesting in observing medical interviews, where silence occurs not infrequently (see Transcript 3.3, Appendix 2). Their model was further refined in the "Simplest Systematics" paper (Sacks et al 1974) to which I referred in Chapter 2, (p.28).

As they looked at the endings of conversations, they found that "Close ordering is then the basic generalized means for assuring that some desired event will ever happen", and that the normal form of close-ordering of turns was the "adjacency pair". An adjacency pair has the following features:

- (1) two utterance length,
- (2) adjacent positioning of component utterances,
- (3) different speakers.
- (4) relative ordering of parts, and



(5) discriminant relations (ie the type of first pair part is relevant to the selection of second pair parts.)

"A basic rule of adjacency pair operation is: given the recognisable production of a first pair part, on its first possible completion its speaker should stop and a next speaker should start and produce a second pair part from the pair type of which the first is recognisably a member."

The close order organization of terminal exchanges included the occurrence of "Pre-closing" actions, or more correctly "potential pre-closings", such as "We-ell", "OK", "So-oo" (with downward intonational contours), as entire utterances. The data I shall use in this chapter are full of such phenomena, and will be explicated later. Even their description of the use of aphorisms ("things always work out for the best") is represented in this data (see 3.2 line 21, 3.3 lines 30-31).

Schegloff and Sacks note that their analysis of closings is only relevant to parties who are not in a "continuing state of incipient talk", such as people in a train, sharing an office, family members in a room, etc. Clearly then it is relevant for medical encounters, the ending of which is often all too pressing.

I have examined my data corpus for ways in which doctors or patients terminate consultations, or appear to attempt to prolong them. Heath (1986) found no instances of patients introducing new topics into the consultation in the closing stages, although he acknowledged that other authors (Byrne and Long, 1976, Browne and Freeling, 1976, Balint and Norell 1973) referred to this "by the way, doctor" phenomenon, or the "doorhandle remark". Using a relatively small number of data extracts, and dwelling on the sequential organisation of the activities, I shall show how the closing of consultations can be "engineered"<sup>8</sup> by the participants, to take account of the time constraint.

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<sup>8</sup> The expression "engineer" is a deliberate gloss on Sacks' term "machine" for the process of "doing talk" (Sacks 1992 vol 1, p.28, Sacks 1985).

## Data extract 3.1 (Appendix 2).

## Transcript 3.1a

15P =myself I can erm (1.0) work about like I do get tired=  
16P =quicker than what I did [ so I mean=  
17D Yeh I should think that's true ]  
18P =I've been doing a bit of decorating at home last week or so=  
19P =but .hhhh where I could paper a wall so've in a day=  
20D mmm (0.5)  
21P its took me about three days [ I get really tired=  
22D mmm mmm ]

In the first extract, 3.1a (above), the patient, a man of about sixty who had had recently suffered a mild stroke, and was complaining of dizzy spells, introduces a new symptom, tiredness, at the very end of the consultation (lines 15, 21). The extract represents the final section of the consultation. This closing sequence began 17 seconds before this extract, where it was marked by the patient standing up and putting his coat on, during which activity the doctor summarised his treatment plan, which he closes at line 1 of the extract (Appendix 2) with a request to see the patient again after Christmas. This is followed by the brief pause, (line 2) and then a longer (0.5 second) pause (line 4), of similar nature to those which Heath has identified as characteristic of doctors delivering diagnoses (Heath 1989). Having received acknowledgements for each part of the utterance ("right", and "right then") the doctor goes on to summarise his prediction for the symptom the patient originally complained of (a "dizzy spell")(lines 6-9). The patient engages (at line 8) in overlapping talk, "oh well", which is followed by another overlapping utterance, "is .... normal like to have kind of attacks like this". This is treated as a "first pair part" (Schegloff and Sacks 1973) by the doctor, whose next turn is "it does happen like this yes yes". The immediate next turn of the patient forms another question-like action: "its nothing really serious them", with the reply "not at all". What is really interesting here is the way the patient adds a qualifier (line 14) "so I feel alright in myself I can erm (1.0) work about like" which leads into a new assertion, "I do get tired quicker than what I did".

So the pattern here seems to be:

- P: A1
- D: A2
- P: B1
- D: B2
- P: Assessment and new symptom (C1)
- D: Acknowledgement (C2)
- P: Amplification (C3)
- D: Acknowledgement (C4)
- P: Laughter

It is as if the patient wants to believe the doctor's reassurance, but has more "story" to bring out before disengaging.

The new symptom, marked by an emphasis (line 15), receives a swift and rather dismissive response, "yeah I should think that's true", from the doctor, which acts as a candidate closing (Schegloff and Sacks 1973). But the patient develops it further, overlapping the candidate close with the next part of the story "so I mean I've been doing a bit of decorating..." (lines 17 - 27). The doctor's responses during this account are a series of "mmm's" and a "yeah". The repeated reference to tiredness (line 21), followed by two pauses, the first a candidate turn transition point where the doctor could have inserted a question about the tiredness, but actually utters only an acknowledgement token (mm) (line 24), and the second being one of a series of hesitations in the account. The doctor's comment about the cost of wallpaper (line 28), is spoken as a fellow home decorator, rather than a doctor, and serves to close off the topic. There is some indecipherable mumbling then laughter by the patient; the doctor resumes his closing sequence with "okay, see you sometime after Christmas", (line 30, 32, compare line 1), but the patient is confused, (line 31) "oh erm". His movement and gaze also suggest uncertainty of where the interaction is going: (see extended transcript 3.1b with gaze added).

**Extract 3.1b:**

(g = gaze; dots and solid line = towards, commas and dashed line = away from co-participant)

g \_\_\_\_\_  
D okay --- see you sometime after Christmas and =  
P ---- Oh er::m -----  
g \_\_\_\_\_

g \_\_\_\_\_  
D =the New Year -----  
P --( )e:::rm -----  
g ' ' \_ \_ \_ \_ \_ ' ' ' ' \_\_\_\_\_  
\*

g \_\_\_\_\_  
D -----yeah lovely okay  
P early in the new year?-----  
g \_\_\_\_\_' ' ' ' \_ \_ \_ \_ \_

As the doctor confirms his dismissal, "yeah lovely okay", the patient looks away (\*). There is no longer a dialogue: co-reciprocity has broken, and the patient accepts the ending of the consultation. Unlike most everyday conversations, but in common with many organised social interactions, consultations in general practice are subject to a time constraint. This consultation lasted a few seconds over ten minutes, which is longer than average, but corresponds to the length of time allotted to each appointment in many practices. Nevertheless, as the doctor starts to use "closing" behaviour (line 1), the patient raises further concerns, tiredness and shortness of temper, to which the doctor seems not to respond (lines 15, 21, 23). When the doctor repeats the closure, there is evidence from the patient's non-verbal behaviour that he is not comfortable with this (extract 3.1b).

**The "by the way" phenomenon in closing.**

This appears to be an example of the "by the way" phenomenon, described by Byrne and Long (1976) (p.28), where the patient introduces a new topic at the closing stage of a consultation, which may represent the "real" problem. They wrote:

"We have had discussions as to whether or not the "by the way" is a genuine example of patient initiation..... Doctors seem to have a limited number of strategies for coping with this sort of event:

- (a) Ignore it
- (b) Defer or temporise.
- (c) Cope
  - (i) Complete reversion to Phase II (discovering the reason for the patient's attending)
  - (ii) Short-term management within the context of Phases V or VI (detailing treatment, or terminating)"<sup>9</sup>

Reverting to my data, once the patient introduces his "by the way", he takes the opportunity of talking about his concern, illustrating it by the effect of the tiredness in his home decorating. Were the doctor to have responded to the new topic in depth, using Byrne and Long's strategy (c)(i) rather than by the cursory acknowledgement here, which Byrne and Long would probably have "classified" "cii", the actual closing, signalled earlier, would have been delayed. It can be hypothesised that the pressure of time is one factor in doctors' non-acceptance of such an offer<sup>10</sup>.

### Data extract 3.2.

If we now consider the data extract 3.2 (appendix 2), where a young man has consulted his GP about pains in the chest and other symptoms, which the doctor has attributed to "stress", the same "by the way" phenomenon is seen clearly. In one sense it is invited: in lines 2-3 the doctor says:

"a::nd you know if you've got anything else that worries you in the meantime come back and we'll check you over".

---

<sup>9</sup> This quotation represents a useful example of the method of analysis used by Byrne and Long, which drew heavily on Bales' Interaction Analysis.

<sup>10</sup> The term "offer" was coined by Balint (1964) to describe a covert presentation of a problem by a patient to a doctor, who thus faced the choice of whether to "accept" or "reject" it.

The patient, who has put on his coat, and stood up to leave, responds (lines 5-7):

"yeah (0.5) I te- som'n that 'as been worryin me bo- (0.9) is of a night e::r I can't seem to sleep (2.0) but lots of things run through me mind."

Rather than let the story develop, as this is a new topic ("som'n that 'as been worryin me") the doctor takes the earliest opportunity (line 10) to insert an explanation sequence, first with "yes" overtaking the word "anxiety", perhaps in the expectation that it was a turn completion, then re-starting at line 11 to assert that this is "not surprising" (line 17). The sequence then is:

D: Closing (l. 2-4)

P: New topic raised (l. 5-9)

D: New topic acknowledged (l. 10-17)

P: Confusion, laughter, no topic-related talk (l. 18-20)

D: Return to closing (l. 21-23)

Detailed examination of movement (Transcript 3.2b, overleaf) during this sequence shows that the utterance at line 5 is preceded by movements of the patient's right hand which begin at the 0.5 second pause in line 2. The purpose of these detailed transcriptions of body movement is that, in conversation analysis terms, there are elements of activity here which are observably oriented to and sequentially ordered by co-participants, and which appear to coordinate with speech in a way that suggests they are essential components of the interaction (see Heath 1986). Heath introduced the concept of "recipency" (op. cit. ch. 2) to describe that bodily interaction, including gaze, which both causes and reflects an active relationship between two people. Heath drew on the social psychology of Argyle and Cook (1976) and the naturalistic observations of Kendon (1982), with the early CA studies of Goodwin (1981), to produce a coherent account of the creation and maintenance of recipency in medical consultations.



That he is "using" his hand to augment his talk is shown by both the following gestures. In the first of these, as he describes the problem "I can't seem to sleep", his right hand extends and makes a flapping movement, with the fingers moving as if playing a keyboard. The movement is exactly coincident with the speech, and whatever its interpretation, it is a visible and clearly integral part of the speech act.

The second gesture occurs as he says "but a lot of things run through me mind". He raises the same hand up towards his head, and draws circles in the air with it, around his head. (Here the "meaning" of the gesture is pretty self-evident!). So in the course of this short series of utterances, the patient has combined a series of quite distinct, gross movements with speech, to interact with the doctor, whose gaze throughout this time is steadily at the patient.

If we can make such a strong link between movement and speech, then we can reasonably infer that his first gesture, the twitching fingers, suggests that his insertion of the "by the way" was actually beginning before the doctor's "invitation" to bring "anything else", and was actually starting in the turn-transition space during the doctor's 0.5 second pause (line 2), preceded by a drawn-out "a::nd".

In considering a third example, I shall invoke the notion of "deviant cases" (Heritage and Atkinson 1984 p.2), where, having proposed a pattern of commonly occurring conversational activity, a case where it does not occur is examined, and explanations sought from within the data itself.

### Data extract 3.3

Extract 3.3 (Appendix 2) may be such a case. It follows a similar pattern to the previous two, but at a slower pace, and with less apparent pressure by the doctor to close. The patient's talk during the pre-closing section is less obviously a new topic, but nevertheless still different from the previous topic. In the consultation, prior to the transcript, the doctor has been telling the patient that he has a heart condition, for which nothing can be done (see line 30-31). The whole section from line 1 (pre-closing) to line 19 focuses on the issuing of a "sick note", requested in line 6. At line 10 there is a statement by the doctor analogous to line 3 in the previous example, inviting the



patient to return if he has any problems. Then, in a sequence marked by pauses and mutual gaze, the doctor addresses the patient's "worry" (lines 19-28)(see transcripts 3.3a and 3.3b below).

**Transcript 3.3a (detail from lines 19-24)**

(m = movement)

```

gaze ... _____
D   don't er don't worry about what I've just told you its not
P   -----no
gaze _____

g   _____
D   er-----,-----,-----,---aagh-----
P   -----,(okay)--((smiles))-Im not the worrying type--
g   _____'----_ _ _ _ _'-----
m   _____
      *
      ((shrugs, leans forward))
    
```

The brief (0.4 sec) turn of gaze away from the doctor in the extract above, (\*) with an accompanying shrug of the shoulder, leads on to the patient reassuring the doctor, ("I'm not the worrying type"), and their engaging in a series of reciprocal glances.

The patient makes an abortive movement to receive the sick-note before the doctor gives it (Transcript 3.3b) (overleaf):

## Transcript 3.3b (Detail from lines 25-28)

(h = hand)

h \_\_\_\_\_ (flicks paper between hands)  
 D get a bit fed up about that .....  
 P .....I find plenty to take me=  
 h \_\_\_\_\_ (moves to receive paper)  
  
 (gives paper)  
 h \_\_\_\_\_  
 D .....mhh mhhh.....I think  
 P mind off it.....thanks very much.....  
 h \_\_\_\_\_ \*\*\*\*\*  
 ((takes paper))((stands))

The receiving of the sick-note, which the doctor spent the previous several seconds writing, becomes the marker of the end of the consultation. Anticipating this the patient appears to have misinterpreted the doctor's gesture, in which he "played with" the sick note and went to take the note from his right hand at that point. As the doctor's left hand returned to the note, signalling that this was not the moment of hand-over, the patient quickly, and unobtrusively, withdrew his hand. Satisfied by this, the doctor smiled and deliberately handed over the note. Immediately on receiving it, the patient stood up. This sequence clarifies the role of the handing over of a piece of paper as the signal of the end of the consultation (Heath 1986, p 132).

The announcement marker "We::ll" in line 29 prefaces a candidate new topic ("there's no good doing much else? is there."), which acts as a first pair-part for the doctor's reply "no (.5) there's nothing you can do about it". The patient's overlapping response "I don't think there is anyway (2.0) bit of a fatalist in that respect (.) heh heh heh" constitutes an acceptance of the doctor's response to the candidate new topic of "there's no good doing much else? is there.", and the interaction moves into a brief closure sequence (lines 34-38).

The difference between this case and the other two lies not in the pattern of introduction of a candidate new topic in a pre-closure stage, which happens in all three, but in the absence of apparent time pressure here. In this extract there is a total of 47

seconds of silence out of 96 seconds, of which some twenty-six seconds were spent with the doctor writing the "sick note", and thereby out of reciprocity. There are more pauses than in the previous examples, and from lines 17 to 28 there is almost continuous reciprocity of gaze. There is no sense that the doctor is telling the patient what to do or even think, but rather they are sharing a conversation, which draws to a mutually agreed conclusion. The candidate new topic becomes incorporated into the current topic, as neither party appears to wish to pursue the hypothetical "else" that might be possible, but both are agreed is not.

### Conclusion

Heath (1986) asserts that "in the corpus of data of medical consultations and other forms of professional-client interaction there are very few instances in which a proposal to finish the business in hand are declined" (p.142). That being so, it is interesting to identify exceptions, and explore how they occur. In the first example, a new symptom, albeit within the broad topic of the consultation, was introduced (tiredness), and not oriented to at all by the doctor. In other methodologies, such an activity might be labelled (or "coded") a "rejection". In CA terms, what we can see is a preferred action by one party, in this case identified as "doctor", to disregard a candidate "complaint" during the closing phase.

The analysis has explored how patients show by their movements as well as speech that their interaction with the doctor is locally organised with "sequential implicativeness" (Frankel 1989). This analysis could allow medical teachers a new vocabulary with which to describe activities in trainees or students which might be associated with desirable outcomes, such as the following up of "by the way" statements or questions (Frankel, op. cit. 1989, p.45, makes this point).

The extension to this study which I feel would be extremely interesting, would be to collect data from general practitioners who customarily consult at a very rapid rate (ie more than twelve patients per hour, or less than five minutes for each patient). I think to do so would not run counter to the CA "tenet" that data should be opportunistically gathered, without prior hypotheses. Rather, it would be broadening the database, and allowing an exploration, without prejudice, of how those doctors and patients organise

their interactions. My aim in doing this would be to document the activities of a wider range of doctors, particularly to see how patients themselves organize their actions in a shorter time-frame.

## CHAPTER 4: MEDICAL RECORDS IN THE CONSULTATION

### Introduction.

Heath (1986) in his "postscript" on the use of medical records and computers during the consultation alludes to Weber's work on bureaucracy, with its observations on the importance to any organisation of files and documents (see Albrow 1970). Interaction analysis, that is, conversation analysis which incorporates as much non-speech activity as the video record and the transcription system allow to be resolved, enables the researcher to explore the impact of such "inanimate" objects on the interpersonal communication process, and on its in-situ organisation. My observations seek merely to build on those of Heath, while also setting some starting points from which future work on the impact of computers in the consultation can develop.

The data for this chapter is a series of consultations by one general practitioner, recorded before the practice became computerised, in 1990. The phenomena of interest are those associated with the medical record, sometimes called the "Lloyd George Record"<sup>11</sup>. Heath's account includes a brief overview of the nature of these records: they are written on small buff-coloured cards (about A5 size), which are filed in similar sized oblong envelopes, which can be gusseted if the number of cards, and hence the thickness of the file, so require. Traditionally the notes kept by general practitioners have been brief, but there has been a recent trend to keep more structured records, using a variety of special cards, in addition to the usual plain lined cards. The envelopes

---

<sup>11</sup> So called because Lloyd George was Minister for Health at the time of their introduction in 1911

also contain all documents received in the practice from other parts of the health service, such as letters from hospital clinics and wards, reports from laboratories on tests ordered by the GP, and other letters relating to that patient.

The particular observation I wish to explore is the way this doctor appears to follow a consistent pattern of use of the records. Before sending for the next patient, he reads the case notes, sometimes pressing the button which summons the next patient *while* reading. When the patient enters, his opening words appear to be contingent both on his prior knowledge, and on what he has just read. During the consultation he sometimes reads the notes but seldom writes in them. As soon as the patient has left the room, he writes.

I would argue that the case-notes constitute a material constituent of the doctor-patient interaction, colouring the interaction from its start, and creating new influences on the next meeting. I am interested to observe what part the patient might play in either the interpretation of these notes, or in their creation.

The data for this chapter comprises one three-hour video-tape, of one doctor conducting a routine morning surgery. Fourteen of the consultations have been partly transcribed, (in Appendix 2), while more detailed transcriptions are included in the text. It is important to re-emphasise that the data for CA does not comprise the transcripts, but rather the original recordings, audio- or video-tape, together with any transcripts, which, by the detail which they may reveal, can supplement the electronic record (Heritage and Atkinson 1984 p.12).

### 1. Gaze and reciprocity

The first datum represents an elderly lady who consults about a continuing problem with her throat. Transcript 4.1a (below) sets out the opening 19 seconds (lines 1-10) of the full transcript, which is found in Appendix 2.



The absence of a reply to the first "so how are you" cannot be fully explained from the data, since the patient is just out of vision until the point where the transcript shows her moving towards the chair. It could be that her gaze is not at the doctor, but the moment she is seen on the tape, she is looking straight at him. His gaze, we have already noted, is not at her once he starts to speak, so it would appear that this is an example of failure to establish reciprocity (Heath 1986, chapter 2). Heath comments:

"The power of the look features in human communication and interaction. .... Being looked at renders one the object of another's attention; it shows that one is being taken account of in some fashion and that one may be subject to the expectations of another." (p.45)

The effect of mutual gaze is seen in this case, particularly as the loudness of the two parallel utterances "how are you" is similar, apart from the emphasised "are" the second time.

## 2. Reading and speech

### Data extract 4.2

Moving to the next extract from the same encounter, (Transcript 4.2, Appendix 2) what is interesting here is the way the reading of the notes is associated with considerable perturbations and hesitations by the doctor (whose ability to speak fluently is clearly evident elsewhere in the data). Heath (1986) comments on this (p.155-6) but in respect of the patient, while the doctor is reading. Here we see the same phenomenon, but by the reader. The hesitations start at line 7, although there is some evidence for patient hesitation at line 3, where the doctor is starting to look at the notes. The linear relationship between doctor's face, patient's face, and notes, which first arose at the start of the consultation, before the doctor sat down, has re-emerged, as he stood up to examine the patient's throat. thus while she is talking to him, her gaze is fully directed at his eyes, although he is actually reading from the notes, which are again in line with her. These perturbations and repairs are associated with the doctor's gaze being almost wholly directed at the case-notes, and then at the piece of paper retrieved from the envelope, which appears to be the blood test result. As he looks at this, the patient makes a variety of gaze-shifts, from the record to the doctor, then to the "middle



distance" (Heath 1986), and back to the doctor as she completes her utterance "at Sefton ye:s".

**Transcript 4.2a (detail from lines 6-12)**

m(doctor standing, taking cards out of envelope)

g -----  
 D well we've had yeah we've had e:rm-----,-----,-----,-----  
 P -----,-----,-----,-----,-----,-----,-----  
 g ----- .....-----''''----- .....  
 (at notes) (to doctor) (to notes) (to doctor)

(looks at report)

(looks at watch)

g -----  
 D erm-----,-----,-----bu-w:-a blood test you had on the fifteenth?-----,  
 P -----,-----,-----,-----,-----,-----,-----at Sefton--ye:s---  
 g -----''----- .....  
 (away) (to doctor)

(at report)

g -----  
 D e:rm-----that-that was ner normal  
 P -----,-----,-----,  
 g -----

The same phenomenon occurs in example 4.3, as the detail transcript shows:

**DATA EXTRACT 4.3 (516 on JVC port).**

1D I'm just trying to see (.) do we have any record of you : 2D ev: having  
 had er: (2.0) Oh you had trimethoprim (.) from 3D us in (.) nineteen eighty  
 s::ix

(9.0) ((reads notes))

4D but there's no you didn't come back to us at least for that

TRANSCRIPT 4.3a

(gaze at notes throughout)

g -----  
D .hhhhhhh I'm just trying to see---do we have any record of you have having had er -

(turns page)

m xxxxx

(gaze at notes throughout)

g -----  
D -----,----- oh you had trimethoprim ----- from us - in - nineteen eighty s::ix

Here the doctor's gaze is at the medical notes throughout, and his comment "I'm just trying to see" is a reflexive account of what he is doing. Nevertheless, his speech is less fluent than otherwise, with gaps of 0.3 seconds, 1.5 seconds, and 0.6 seconds during the single utterance.

Another example of doctor speech while looking at notes is:

DATA EXTRACT 4.4

D can you drop up to se- oh I'm just looking back to see when you last had a blood  
g -----

D count done-----,-----,-----,-----, .hhhhh it was when-----  
g -----

D can't see the date----eighty six---.hhh y'blood count was a little bit low then--  
g -----  
m xx xx xx

(turns page)

D what way 've your periods been?--oh youve had one more recently  
g -----  
m xx  
(turns page)

Here the doctor's talk is entirely done with gaze at the notes, but there is a "partial reciprocity" maintained by the alignment of the actors: doctor and patient are sitting at adjacent corners of the desk, at an angle of about 150 degrees (ie almost face-to-face) with about six inches space between their knees. The records are on the doctor's lap, such that he is looking down, but in the direction of the patient's face, while the patient is looking at him.

### 3. The content of the record.

The content of the written record, if read, contributes to the doctor's image of the patient and of the consultation: the opening exchanges are frequently observably contingent upon the content of the record. The patient has no part in this process, as it normally takes place before they even enter the room. The next extract (Transcript 4.5, Appendix 2) shows how this prior reading colours the nature of the opening exchanges. A man who had been seen recently with a chest infection returns, and is greeted by name<sup>12</sup>, (4.5 line 1), but the next doctor utterance, "are things improving?", clearly relates to prior knowledge held by both parties.

Detailed transcription of gaze around lines 3-10 (4.5a) shows the doctor's gaze move to the notes as the patient starts an utterance "I finished them course of tablets today".

#### TRANSCRIPT 4.5a

(notes)

G \_\_\_\_\_''''-----  
 D -----are you-----yeah-----,-----,  
 P green up-----yeah----I finished them--course of tablets

(notes)

G -----''''-----  
 D ---ri::ght-----,-----,-----,-----,yes the capsules  
 P today-----,-----,erm-- the--red-----,(.....)

---

<sup>12</sup> All names of patients and doctors have been changed to preserve their confidentiality.

This utterance is punctuated, briefly but noticeably, by a pause after "them", and then 2 whole seconds before "erm", and further gaps in the remaining utterance, despite the return of the doctor's gaze just after the "erm". The continuing hesitancy may be here to do with the topic: the patient is trying to describe his treatment, but does not appear to know its name. "Yes the capsules" is spoken as the doctor looks back at the notes, suggesting that they were the source of his confidence in asserting the nature of the tablets.

The next data extract (4.6a, below), a detailed transcription of extract 4.6 in Appendix 2, further demonstrates the phenomenon of the doctor looking towards the notes in relation to speech about their content.

**TRANSCRIPT 4.6a (lines 10-15 with gaze)**

(at doctor)

g: \_\_\_\_\_

P: I need a-----me pill--prescription and I wondered if you'd

D: -----hhhhhhh-----ri:ght-----,-----,

g: \_\_\_\_\_'''-----

(to notes)

m: ((turns page))

g: \_\_\_\_\_

P: take me blood pressure for me-----be great:-----

D: -----,-----,-----I will yeh-----yeh--

g: -----

(at doctor)

g: \_\_\_\_\_'''-----

P: -----Logynon-----

D: -----now let me---just think what what pill are you taking?-----ri::ght

g: -----

(at notes) xxx

m: (turns page)





retired five years previously). By reading the notes, this doctor was able to make the statement "Never met you before missus Cooper", while being able to address her by name, apparently correctly!

The same action occurs in the following brief extract 4.10:

#### Data extract 4.10

1D        Good morning (6.0)  
 ((puts record away and picks up another))  
 2D        Gillian Smith  
 3P        mmhm  
 4D        I'm doctor Murphy (0.5) I don't think we've met before  
 5P        no we haven't

Here the appearance of the patient is followed by the doctor putting aside the records he is holding, and drawing another from the desk, from which he reads a name, to which the patient answers. The statement "I don't think we've met before" is less firmly asserted than the previous "never met you before", perhaps because it is not based on a reading of the notes, but simply on him not recognising the patient.

#### Data extract 4.11 (Appendix 2)

Finally, extract 4.11, the start of a consultation by a different doctor, which is considered more fully in chapter 6, shows again the effect on the interaction of the doctor reading the notes during the consultation. The pauses are longer than in "normal" conversation, and reference to the tape (extract 4.11a, below) shows that at lines 7-9 this corresponds to the doctor reading the case-notes.





Thus the record, paper (or computer, as other work by the author and colleagues (Greatbach op. cit.) has shown), is much more than a passive document. It becomes a dynamic part of the interaction, by the way the participants notice its content, physically handle it, and interpolate their speech into its use. Myerscough (1989) writes of ways of facilitating communication thus:

"At certain points it is helpful to discard pen and notes in an obvious way, and push them to one side..." (p 33)

and "during periods that are intensely emotional, it is appropriate to set aside note-taking and devote all attention to what the mother is saying. The note can be completed after the mother has gone." (p 77).

He thus acknowledges the potential *inhibiting* effect of records on interaction, but fails to draw out the converse *facilitating* potential which, from my analysis, I believe exists. In another widely used text for medical students, "Clinical Method" (Ed. R Frazer, 1992), Preston-Whyte's chapter on doctor-patient communication includes the following observation made by a patient:

"You'd sit down in front of his desk and usually he'd be writing something and you's just sit down and wait until he looked up...." (p. 96).

She comments that "the setting of the consultation can strongly influence the type of communication", but seems not to have built on this patient's powerful observation that writing in notes inhibits talk. The chapter does however encourage students to observe their own consultations, preferably by video-recording, and to learn from their own observations.

My data from this chapter suggests that the medical record is an object which should not be "taken for granted" in the consultation, nor simply "set aside" at moments of extreme emotion, but understood for its considerable interactive potential, whether paper or computer. This therefore implies that learners need additional information in order to make sense of the video-recordings they are all going to make.

## **CHAPTER 5: TALK AND TREATMENT**

### **Introduction**

One of the frequently done tasks in general practice consultations is the issuing of prescriptions. There is a commonality in this activity, whatever the nature of the medicine being prescribed, or the number of items, which comprises the doctor writing (or, in computerised practices, generating through the computer) the name, address, age (if under twelve) of the patient, then the name, form, strength, quantity of the drug or preparation, and instructions to be given by the chemist to the patient, then the date, and finally, in either case, the doctor's signature. Prescriptions, insofar as they enable people to obtain medicines otherwise unobtainable ("Prescription only medicines"), or, more controversially, unaffordable, represent one of the frequently acknowledged reasons for patients seeing doctors (see Tuckett et al 1985).

### **Talk around prescriptions**

In the large study by Tuckett et al (1985), patients had perceived information about treatment to have been given by the doctor in 100% of the consultations. (This contrasted sharply with information about other topics). The study further showed that understanding of and agreement with the doctor was much less likely, and speculated that this was related to the lack of "reactive explanations", where doctors tailored their explanations to the ideas and concerns of the patients. The implication of this, if the

study is a valid reflection of reality, must be that doctors need to hear what patients have to say, which in turn implies a particular form of interaction.

Jefferson and Lee (1980, 1981) in a large study of naturally-occurring conversations in which "troubles" were talked about, sought to describe a candidate "sequence" or "type" which such talk represented. Ten Have (1989) re-examined this idea in arguing for the status of "genre" for the general practice consultation, albeit using data from the Netherlands, where, however, general practice is very similar to that in the UK (see Huygen, 1978 for a classic description of Dutch general practice). Ten Have's "ideal sequence" resembles the Byrne and Long (1976) pattern of general practice consultations: he showed that participants visibly oriented to such a sequence, and that it was a pattern which frequently occurred in data from general practice. He showed a convergence between the "troubles telling" pattern of Jefferson and Lee (1980) and the service encounter pattern of a routine consultation.

Given that prescription-giving is the commonest form of "treatment" done by GPs, and that Tuckett's study found that some talk occurred around this in every consultation that they examined, it seemed to me reasonable to look at examples of this part of the consultation for systematic organization.

This chapter addresses the question of how doctors and patients structure their talk around prescriptions. It will use data from both "manual" and "computerised" practices, although the question of whether the presence of a computer in the interaction, particularly as a tool for generating prescriptions, systematically modifies the interaction will not be addressed. The author, working with Greatbach, Heath, and Luff (Greatbach et al 1993), has explored this question, finding strong CA evidence for a systematic effect of the computer in this phase of the consultation.

The data shown here is drawn from the whole corpus of this study. I use two extended transcripts, and several shorter extracts, to demonstrate certain phenomena which have struck me as "interesting". Sacks (1992 vol.1, p.3):

"I found something that struck me as fairly interesting quite early."

Sacks' approach to data was not to start with preconceived ideas, let alone hypotheses, and set out to find evidence for or against them, but rather, in an attitude of "indifference", to explore phenomena as he encountered them, only then seeking evidence for their systematic properties. As CA techniques and "perspectives" (Heritage 1988) become focused on particular types of activity, some of the randomness of Sacks' approach has become lost in favour of some prior orientation.

The datum transcribed as Data extract 5.1 (Appendix 2) shows a prescription being written, (indicated on the transcript by asterisks at start and finish) with doctor talk continuing for most of the writing. In this extract, the doctor indicates his intention to write a prescription by a statement (lines 1-4), then during the writing states the nature of the medicine (lines 6-7), and discusses the particular form (lines 11-13). Later (line 16) he asks the child's age, possibly because he needs to write it on the form, followed by a six second period of writing, interrupted by the mother giving an account of her reasons for seeking help at this stage in the illness (line 19-20):

19M: "we keep expecting it to go in the next day or so and when (.) it doesn't well,

This speech is immediately preceded by a sharp intake of breath by the doctor (line 18), who nevertheless continues writing steadily, but acknowledges the talk by slight head nods.

The mother's initiation at line 19 clearly interrupts the doctor's inbreath, which would normally signal the start of an utterance, as she recognises that the "mutual pause" of writing has ended. Reciprocity, in Heath's terms (Heath 1986) is re-established.

There are three interesting activities here:

- a) announcement of the intention to prescribe (lines 1-4)
- b) prolonged pauses during writing (lines 5, 15, 17)
- c) patient initiated turn after prescription (line 19)

The announcement of an intention to do something before actually doing it occurs frequently in this data corpus, and is an example of an orienting action, effecting the

shared orientation by both parties to the action announced. Similar things are found in data extracts set out in chapter 8, where doctors say:

"right okay (0.5) good so it sounds a'we probably have a listen to your chest",  
 "probably sounds as if we need to:: up the er dose back up again for a longer  
 time"  
 "We'll give you some paracetamol too".

A second piece of data (Data extract 5.2, Appendix 2) shows similar phenomena. The patient had previously been prescribed an antibiotic for a sore throat, and had developed new symptoms which she attributed to the drug (see lines 5, 8). The doctor begins with a newsmark "well", followed by the announcement:

10: Well I'll give you some antibiotics that wont upset your tummy or are  
 very unlikely to upset your-="

This announcement is here followed, or rather actually cut into by the doctor's account of the ill-effects of the particular antibiotic that had been taken ("erythromycin")(line 4), which the patient interrupts (line 5) with her own "troubles" from taking it. The doctor re-starts his account at line 11, and re-formulates his announcement (lines 14-15) in terms of "let's hope you can get a (.) proper course of antibiotics this time".

Now there is absence of talk for the 6.5 seconds of writing, before the next exchange, which is done while the doctor is still writing (lines 17-22), shows very brief responses from patient (lines 18, 21).

The patient-initiations at lines 23 and 25 are the main object of this analysis, as they represent the third of the three activities I suggested were a pattern of organization. The first of them (line 23) appears to occur before the finish of writing, and hence to be an exception to the rule that patient initiations occur after the finish of writing. The second occurs as the doctor finishes writing, and cuts into the doctor's hesitating reply to her first question. Detailed scrutiny of the data (transcribed below) shows that there is a movement of the doctor's head (shown by the shift of gaze, marked by an asterisk\*) as he glances from his writing back to the case notes, which immediately precedes her question "for how long":

## TRANSCRIPT 5.2a

(writing) (stops writing)  
 m xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx  
 g (at pres)(to notes) (to patient)  
 g (to prescription)  
 g ----- .....  
 \*  
 D -----,....., .hhh well really while youre taking them  
 P -----, °hhh for how long°?-----,  
 g -----.....  
 (to Dr)

Thus the patient takes an inbreath as the doctor's gaze moves from his writing to the notes (which refer to, and are a proxy for, her) and speaks her question, even though he has continued to write. His writing continues until the moment he starts to speak. The patient's rather quiet question contrasts with the doctor's loud, slightly irritated reply, but her next turn is much more firmly stated, as she has re-established an interaction, in fact by using an adjacency-pair device with a third turn (lines 23-25) (see glossary).

#### Maintaining involvement.

A further example, (Data extract 5.3, Appendix 2), from a different doctor, can be used to explore how patients generate and maintain involvement during the treatment phase of the consultation, here in the context of a patient whose smoking has been identified by the doctor as problematic, and who is being persuaded to address the issue himself. The extract starts with the same announcement of the doctor's intention to prescribe (line 1):

10 With you the way you are at the moment actually youre bringing a lot of this stuff up and you have been for a while I will give you a short course of antibiotics

This is followed by the beginnings of the prescription writing, which has been omitted from the extract. In line 13 he invokes an argument to support his advice to the patient to stop smoking, but this the patient interrupts (line 16) first with a newsmark "well", followed by a brief pause, where the turn could have been taken by the doctor, but is not, then the patient makes his initiation by an expressed interruption, a "formulation"

(Heritage and Watson 1980) "can I just interrupt doctor", which prefaces a disagreement (Frankel 1990).

This patient keeps the initiative by asserting (line 18) his argument, that because his wife is also a smoker, there is little point in him accepting the doctor's advice without her involvement also. Writing actually starts in the middle of line 18, but here the patient continues to speak while the doctor writes (5.3a, b, c):

**Extract 5.3a: ("x" represents doctor writing)**

```

                                                    ((mimics cigarette))
(hand)                -----
19P    she gets a cigarette and just goes phh
20D    -----
(write) xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

21P    and puts it out (.) she smokes twenty-five a day (.)=
22D    -----yeah-----
(write) xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
    
```

At line 21 a short pause (less than 0.2 second) precedes the doctor stopping writing, when the patient continues his speech. The short pause, followed by the emphatic "she", results in the doctor pausing in mid-prescription, and turning towards the patient (5.3b):

**Extract 5.3b (with gaze (g) and writing (w))**

```

23P    =so you can imagine the the cigarette bill -----
D      -----
g      ----- .....----- .....
                                           (to pad)

24D    well not just I mean even though she does that she's still
g      ----- .....-----
(at pad)
    
```





**DATA EXTRACT 5.4a:**

(Comp-2 Dr PDC), (Pt young adult male with painful shoulder, doctor has just injected the shoulder with a steroid drug.)

- 1D I'm goin to give you a prescription if I ma::y (.5)  
for um the stuff Ive just injected d:do you pay prescription charges
- 2P e::rm  
[
- 3D should do if you're unemployed (1.) you can get dressed
- 4D ((25 secs typing))

In the same way as the previous examples, the prescription is announce by a statement (line 1). The striking difference, found in most computerised prescribing, is the long, 25 second, silence while the doctor types.

The next turn is the patient's:

**Extract 5.4b:**

- 5P what do I do with that?
- 6D what Id like you to do is take it to the chemist and  
(.5) erm (1.0) drop it back in.
- 7P okay.
- 8D he'll give it to you (.) its just a box of injections,

Again the three phenomena are (a) announcement (line 1), (b) absence of talk (line 4), and followed by (c) a patient-initiated utterance (line 5).

Other studies (Greatbach et al 1993) have shown that the trigger for such patient initiations seems to be an appreciation by the patient of the fact that the doctor has reached the end of the typing sequence. Patients were shown to coordinate their utterances with "last keystrokes" of sequences, which were identifiable by being harder than other keystrokes.

Patients use systematic sequential devices to maintain involvement when doctors are writing: do doctors adopt behaviour that has the opposite effect? The next data, extracts

5.5 and 5.6 (below) show a doctor whose patients appear not to take up the third activity (initiating a new topic) after a prescription:

**DATA EXTRACT 5.5 (SMil 1):**

(19 sec) ((writes prescription))

1D\* How often are you using the oil?

2P I have a bath every other day and than.

3D Right I'd like you to oil once and week and gradually wean yourself off it.  
OK?

(8.0)

4D and just use the eardrops while your ears are irritated then you can stop using it.

5D I::.

[

5P Mmm

6D Keep it in the house, because they might flare up again.

7P Mmm.

8D OK.

**DATA EXTRACT 5.6 (S Mil 2:)**

1D Yes

(13 secs)((writes prescription))

2D\* You can use this 4-5 times a day. It depends how much er, water you are getting on your hands. Try to keep them out as much as you can, but obviously you can't.

3P Well no.

4D Try your hardest. There you are.

5P Thank you very much. Bye.

In these two extracts, the doctor appears to inhibit patient talk by her own activity: as she completes the prescription she immediately asks a direct question (line 1, extract 5.5) or initiates instructions (line 2, extract 5.6). This pattern was consistent for this doctor, for whom I have video-recorded data of a full surgery of 10 patients.

Byrne and Long (1976) addressed the issue of doctors' "style", and showed, in terms of their research paradigm, that style was a relatively fixed phenomenon, remaining constant within each doctor over a range of consultation types. This doctor would be classified by their method as having a "doctor-centred" style, which in conversational terms allows little opportunity for the patient to initiate turns.

### **Discussion**

There has been a substantial shift in the status of the doctor's prescription, from the time when it was unintelligible to a layman, by being written in "latin", together with an obscure system of symbols representing apothecaries' measures, to the present computer-generated form, printed in plain english. Simultaneously has been the shift in intention, from conveying an "order", such as "take one tablet four times a day", to the inclusion of a patient information leaflet with each item dispensed, and the printing of the name of the drug clearly on the container.

It is not surprising therefore that patients now want to be more involved in the process of receiving a prescription, and ask questions about it. This chapter has shown the ways in which patients interpose their questions into the doctor's "writing time", which reflects the general assertion of CA that interactions are systematically and locally organised, by the mutual orientation of speakers to each others' activities.

## CHAPTER 6: FACILITATION?

Some doctors sound as though they are grunting whilst others "Mmmmmm" endlessly.  
(Byrne and Long 1976)

Sacks noted in a lecture in 1966 (Sacks 1992, vol 1, p.311) that a speaker can "get participation" in a monologue by pausing briefly with questioning intonation, providing space only for "uh huh", "yes", but later (Spring 1968: op.cit. vol 1 p.766-7) observed that there was within the class of objects of which "uh huh" is a member, a number of alternatives which appear to act differently from "ordinary uh huh's". These included "How nice", "Oh that's too bad", or "That's good", and served in the context of a story-telling to orient the hearer to a pre-announced feature of the story being told.

"I had for a long time made the argument that a business of "Uh huh" was something that we talked of as serving as a "continuer". The idea being that it said to the person who was speaking before it that they could go on after it with whatever it was that they were talking about." (Sacks 1992 vol 2, p. 410)

He went on to argue that such a "continuer" could be viewed as a "pause-filler" by the hearer in the speaker's pause, and that such a usage is observably anticipated by the hearer, because the timing of "uh huh's" is quite precise (see also Schegloff 1981).

Ten Have, looking at the phenomenon of "asymmetry" in the doctor-patient interaction, noted that "a similar lack of information is engendered by physicians' use of the "third turn" in questioning sequences: items like "okay", "uhuh" and "yes", as well as summarizing formulations, do not display for the patient what the physician makes of the answer, but only mark whether or not further elaboration is needed." (ten Have 1991)

p.141). Thus not all uses of "uhuh" and the like are necessarily "facilitatory", indeed may act in the opposite way.

Jefferson (1978) noted in a discussion of "sequential aspects of storytelling in conversation":

"two features via which a story can be seen to articulate with turn by turn talk: Stories emerge from turn-by-turn talk, that is are *locally occasioned* by it, and, upon their completion, stories re-engage turn-by-turn talk, that is, are *sequentially implicative* for it."

Thus although a story might appear to have its own momentum, there is good evidence that it actually depends on close attention by both parties to the other. "Facilitation" might be a term applied to activities which enable the starting, continuance of a story. Not all consultations include "stories", but many do, in the sense of descriptions of events that took place in the past, and are being told by one to the other.

Byrne and Long (1976) in seeking to describe "the minutiae of the consultation" (chapter 4) classified what they called "behaviours used in relating to patients" into 13 categories. These were said to be derived empirically from their data, and when set alongside CA work such as Frankel's (1989), bear superficial resemblance. The key difference of approach lies in the origin of the categories, which for Byrne and Long, as for Bales, were observer-defined, while for CA categories must be member-defined.

**Byrne and Long's categories:** (this is not a complete list, but examples from their categories relating to the beginning of a consultation).

Giving recognition	Offering self
Apologising	Dysfunctional openings
Telling (giving information)	Direct questions
Encouraging	Using silence
Relating to some previous experience	

They used the category expression "encouraging" without defining it, but gave three examples of what they meant, which were: "Go on", "Tell me more", and "Uh, uh". They add:

"the examples given are only a few of the various noises doctors use to encourage patients to keep talking. Some doctors sound as though they are grunting whilst others "Mmmmmmmmm" endlessly." (p.36)

This chapter will address the ways in which doctors and patients in general practice organise the interaction through the use of these short utterances, which might be called "acknowledgements", to try to understand how they work.

The first datum I shall consider is the whole of a fairly short consultation in general practice, conducted by a "trainee" general practitioner<sup>13</sup>. The object of interest is the doctor's use of "right", which, if we include his use of "alright" in the count, occurs no less than nine times. From my (British) data, it appears that "uh huh" is less common than other expressions in the same class, such as "yeah", "right", and "mmm". (Compare Sacks 1992 vol 1 p.764).

Data: transcript 6.1 (Appendix 2)

#### Extract 6.1a

M=mother; P=boy; D=doctor

1 M     Its er eez (0.5) got a lump (.) on his left breast (1.0) >yeah iz left breast  
          tha one

2 D     ri::ght=

3 M     =(just beneath the nipple)

4 D     ri::ght  
          [

5M        (            ) the nipple

Here the doctor's hesitant "ri::ght" (line 2) is followed immediately by more talk from the patient, in this case the mother of a 12 year old boy with a lump in the breast. At such a "turn transition point", the doctor could have asked a question, as he did later at lines 6 and 12, or moved to examine the boy. By saying nothing, in the sense that "right" conveys no literal meaning of the "rightness" of the mother's utterance, the doctor signals his receptiveness for more of the mother's story. The term "facilitatory

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<sup>13</sup>A Trainee GP has worked as a junior doctor in hospital for at least one year, and spends one year under supervision in general practice, with two further years in hospital posts. After this they are entitled to practice independently.

acknowledgement" might be applied to this object, which resembles the class of objects described by Sacks under the heading of "uh huh". It is facilitatory, because it makes easy the continuation of the other's turn, while it is an acknowledgement in that it shows the other that their prior talk has been heard. However, the doctor repeats the "right" following the mother's qualification of her initial statement of a lump on his left breast, and this one is overlapped by an unintelligible utterance ending with the clear repetition of "the nipple", so it is likely that this was a "replacement" (Sacks 1992 vol 2 p.413), where a party reproduces an utterance in a modified, simplified form in response to a request for a repeat. Here, the doctor did not indicate he had not heard or understood, but the mother's response is as if that is what she had heard.

The exchange continues with a more discursive account by the mother of the context:

#### Transcript 6.1b

5M ( ) the nipple  
 6D [ when did you notice it first.  
 7P eh when I wuz (.) away.  
 8M he was down at his er (.5) brother down at Fleetwood.  
 9D ri:ght,  
 10M for a week for his holidays and when his brother (.) brought=  
 11M ='im back he said he::s got a lump,  
 (0.7)  
 12D ri::ght (1.2) (erm) has it been sore at all.  
 13P yes

Twice more the doctor uses "ri:ght", in a way that begins to sound stereotyped. After the fourth time, (line 12), the mother does not continue, but after a 1.2 second pause the doctor introduces another question. The 1.2 second pause is more than enough for a turn transition to occur: the fact that it does not, but instead the doctor continues with a very soft utterance, putatively transcribed as "erm", and then a question, suggests that the mother had no more to say on the subject. Her problem was the lump, and that is what she now gave to the doctor. She had stated it twice, the first time herself (lines 1 and 3) and then by reference to the brother in Fleetwood (lines 6 - 9). "Right" on the

first three occasions served as a continuation device, or a "processing pass", but on this fourth occasion, the turn not being taken up, the doctor appears to fumble his way into a question, "(erm) has it been sore at all". The "right" returns as an acknowledgement of the answer, again followed by a pause, before another question. From being a precursor to more information in the first case, a possible marker of non-hearing in the second, the same expression has become an ineffective device for "facilitating" other's talk.

Further evidence for this "non-facilitation" is seen towards the end of this consultation, where the doctor appears to anticipate the patient's agreement with his "you feeling alright in yourself", by saying "ri:ght" before the patient actually says "ye::s" (Extract 6.1c, line 52).

#### Transcript 6.1c

48D (thats what it is) (1.0) you feeling alright otherwise=  
 49D =in yourself (.)  
 50P er  
 51D ri:ght  
     [  
 52P ye::s  
 53D I mean if it has'nt faded in a month or two Id be glad to (0.5)  
 54D er check it over again for you

This "right" takes the doctor's turn away from the patient, whose response to the question "you feeling alright otherwise", a brief "er" is immediately cut into by the same intonated and prolonged "ri:ght", such that a "yes" overlaps. The next turn is again the doctor's, and is a clear pre-closing device. The final "right", spoken without prolongation (line 57), converts the candidate pre-closing into a definite closing. The mother's reference (line 55) to keeping an eye is affiliated to the first pre-closing, taking up the idea of returning for a check up, but the "right" leads straight into "okay thanks doctor tarra".

Thus this doctor uses the expression "right" where in other consultations doctors have said "yeah", or "mmmh" (lines 2, 4, 9, 12, and also 51 and 57). These utterances can be divided into those that appear to "facilitate" patient exposition, and those that do not. The first three are interjections in the stream of patient talk. They appear to hand over the next turn to the patient, who continues the same theme. Line 12 could have been



the same, because there is a 1.2 second pause after the "right", but the patient does not take the opportunity of continuing, so a question, hesitatingly, follows ("erm, has it been sore at all?"). This is the start of a series of Q-A pairs, and an examination. The "exposition" follows, when the doctor explains his diagnosis and prognosis. The next section is an extraordinary piece of subtlety by the patient, who seems to be challenging the doctor's right to be certain about lumps! The doctor (line 45) takes no notice of this, but re-states his exposition, qualified by a question about the boy's general health (line 48). The mother has the last word, (lines 55-56) by expressing her unease at lumps, and her wish to keep an eye in it.

It appears then that terms like "right" may act as facilitators, as British equivalents of "uh huh", (Schegloff 1981) but may also have an almost diametrically opposite action, as completers.

The next piece of data (6.2, below) concerns the same doctor, and a small child with a skin problem, brought by the father.

### Data extract 6.2 RM 3

F=father; D=doctor.

1F        Eez got sore hands very sore hands (0.5)  
 2F        e::r (0.8) es ad it for about (.) just over two weeks now  
 3D        right?  
 4F        e:rm °I dont know° what it is we've ad cream for it e:rm but  
           (0.5)  
 5F        we've been away on holiday for a few weeks=  
 6D        mm  
           [  
 7F        =you see so (0.5) we couldn't really (0.5)

"Right" is this doctor's preferred choice of acknowledgement token, and as in the previous example, the first use of it seems to have a "facilitatory" effect, as after the "ri:ght?" (line 3) the first speaker hesitates, then resumes his turn. He does not add to the description of the problem, but instead begins an account (Sacks 1992 vol 1 p.72-80) explaining why he has left it so long before coming to the doctor. The transcription of gaze (6.2a, below) enables us to associate the "right" utterance with its accompanying nodding, and the account with the immediately preceding doctor's gaze shift from the

father to his hands, (not, as might be expected, to the child's hands, which are the actual subject of the talk). The father's next turn then begins, but his gaze only moves to his hands after the pause (.), as if he only then decides what to put into his turn. Here, turn construction is observably sequentially organised.

**Transcript 6.2a (lines 2-4) (gaze and movement added)**

((to his hands))

g \_\_\_\_\_'''-----

F just over two weeks now-----e:rm (.) °I dont know° what

D -----,-----,---ri:ght-----,-----,

g \_\_\_\_\_'''-----

^ ^ ^ ^

nods ((gaze to speaker's hands))

Extract 6.2b (below) shows an acknowledgement token "mmm" apparently overlapping with the speaker's turn. Detailed analysis shows that the speaker (the child's father) was still uncertain about what he was saying, 0.5 second pause after "so", and the negative expression "we couldn't really". The doctor's "mmm" is supplemented by a simultaneous nod, and at the point of hesitation, a second nod when the father's gaze shifts away from the doctor.

**Transcript 6.2b (lines 5-7)**

g \_\_\_\_\_'''-----

F for a few weeks you see so-----we couldn't really-----sort

D -----mmm-----

g \_\_\_\_\_

^ ^

nod

**Data extract 6.3 (Appendix 2)**

Turning to the relationship between "facilitatory acknowledgements" and "troubles telling" (Jefferson and Lee 1980, 1981), I was drawn to a particular consultation which I

have transcribed at length, although not in full (6.3). A woman in her fifties responds to the doctor's conventional opening of "What's the trouble" (line 7) with:

"I've actually come fer erm (.) an inhaler".

It would have been quite possible for the doctor at this point to begin "service delivery" talk, and ask for further information about the required object, moving smoothly to the prescription phase of the consultation (Frankel 1989 p.38). The chosen response, "ri:ght °right ye:s°", seems to unsettle the patient, whose next utterance, overlapping with the end of the first "right", is a drawn out

"e:::rm (0.8) I just need a new inhaler (.) actually" (lines 9-10).

A troubles-telling invitation follows, as the doctor, having drawn the patient's medical notes out of their envelope during the 0.8 second pause after line 6, reads from them while she talks at line 10 (which may account for the perturbations here, see chapter 4) and invites a story at line 14 ("how- how is it all going"). The long section which follows, from line 16 to line 70, can be characterised as "troubles telling" sequence (Jefferson and Lee 1980).

At line 71-73, a transition occurs, with first the patient returning to a previous theme, the introduction of the new inhaler treatment (line 30), and then the doctor in a completely different tone of voice, announcing a "medical" procedure, and followed by a very direct question (line 79).

The facilitatory action of "right" at line 9 contrasts sharply with the abruptness of line 77. Other candidate examples of "right" in facilitatory mode are found here, in lines 29, and 70. In line 29, the doctor is leaning back in his seat, not reading the notes, (as might be the case if the "right" were an indication of the correctness of her statement of the dose), and the utterance has the effect of "filling the other speaker's pause" (Sacks 1992), in that the patient takes a deep breath, and continues.

In line 70, "right" is spoken in a very soft tone, corresponding with Sacks' "orienting" activity, here clearly orienting the speaker to the news of the father-in-law's recent death and burial. The remarkable thing is the patient's non-orientation to this "empathy" mark,

by reverting to her complaint of chest trouble. The doctor's move into "service-delivery" at line 77 appears to follow, and be contingent upon this orientation of the patient. In other words, the patient herself drew the troubles telling story to a close with "so 'e only got buried on Friday", and followed the doctor's quiet "right" with a recapitulation of her "service" request.

The relationship of "right", and other such facilitatory expressions becomes even more interesting when the topic under discussion is of an emotional nature. Many consultations are not primarily about a patient's physical symptoms, but rather about an underlying worry. The next consultation, with a different doctor, shows a woman who says "I just feel as though me nerves are on edge".

#### Data extract 6.4 (Appendix 2)

What is particularly interesting about this data for general practice is the way it starts on the topic "these pains and palpitations" (line 4), but moves to "crying, and everything getting on top of me" (line 14), and "I just feel as though me nerves are all on edge" (line 30).

Considering the whole, and noting how turns occur, or potential turns do not occur, lines 4, 8, 10, 12, 14, 18, 20, and 28 all contain pauses within the patient's turn, most of which could be taken by the doctor as potential next-speaker opportunities, but are not taken. It is characteristic of "troubles telling" speech to contain such hesitations, and also perturbations of speech. This doctor (a recent trainee shortly to go to Nepal as a missionary) chooses to "listen", with the interesting, and clinically important, outcome.

From line 23 to the end of the extract there are instances of the "use of silence" by doctor (Byrne and Long 1976). There is a question (l.23), its expected "adjacency pair" answer "ye:s", an extension of the question (l.25), and its pair "no"<sup>14</sup>, but instead of the expected next turn by the doctor of another question, there is a significant 1.3 second pause, followed by a "mm" (l.27). This has the unexpected result of a series of

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<sup>14</sup> Note that questions in speech do not necessarily contain the grammar and syntax of "questions".

statements about her state of mind and her behaviour with the kids, which are clearly the most telling and important utterances so far, and highly relevant to the whole picture of the problem which this lady is being enabled, by the activity of her co-participant, to reveal.

If we consider the range of components of "intersubjectivity" (Schutz 1967), and look first at the bodies themselves, it is apparent that this doctor, having turned towards the door as the patient enters, adopts a position as he says "I'm doctor MacDonald" seated at the corner of a desk, his legs slightly apart, his hands folded in his lap, facing directly towards the chair on which the patient has sat. She, in contrast, sit with her legs crossed, and her body inclined some 30° away from the doctor.

He moves his gaze away from her between lines 7 and 9, where he reads the case-notes. This phenomenon is discussed in detail in Chapter 4, in relation to the medical records. Here, it appears to be a distraction from what is otherwise a highly focused interaction. As he finishes the utterance "what happens, exactly", he resumes the former position, only with one hand stroking his beard, and maintains it throughout the rest of the extract, which lasts 1 minute 36 seconds altogether.



Here the doctor's nod precedes the patient's utterance "like a panicky feeling", suggesting that the patient is indeed watching the doctor's face for information. The nod actually starts during the hesitating "e-er".

**Transcript 6.4c (line 14 with gaze and movement)**

P	like this:: -----,--- an I was cryin an everything ----- feels
D	-----,-----,-----,-----,-----,-----
g	-----
m	* (nod)

The very slight nod here is again immediately followed by the next utterance. This patient shows how co-reciency involves a close monitoring of the other's activity. Schutz reflected on the nature of this in his paper on "The dimensions of the social world" (Schutz 1964 pp 20-63), where he developed the ideas of the "pure We-relationship", in which there is perfect paying attention by each to the other, the "Thou-orientation". There are degrees of intensity of we-relations, which are actualized in concrete ways, such as those described here.

**Data extract 6.5 (Appendix 2)**

Here the patient's "story", lines 15-31, emerges after a series of questions (lines 5, 9, 11, and 13, and appears to be "facilitated" by the doctor using a succession of "yeah" and "ye::s" utterances. The transition from a Q-A sequence to a story-telling is accompanied by a very interesting piece of movement. At the start of the extract the doctor is sitting at the corner of his desk, facing the patient across the corner, as he completes the blood-pressure taking. At the end of line 6, he moves sharply to stand up, and moves across the room to pull something nearer to the patient (possible the weighing scales). At the beginning of line 14, he sits down, not in his own chair, but in the chair immediately beside the patient (placed there for when two patients attend together). The baby in question is sitting on the floor in front of them. The appearance is of two people sitting together on a park bench, one telling a story, the other listening intently, uttering "yeah", and "mmm". The detailed transcription of gaze and movement shows the

interaction between speech and movement, as the doctor, speaking of the child, looks to the child as he sits down, then turns his gaze sharply to the mother, which involves almost a 90° turn of his head to the left. This movement, marked with an asterisk in 6.5a, coincides with the start of the mother's story.

**Transcript 6.5a** (lines 13-17, gaze and movement added).

	(moving to chair)		(sits beside patient)
m	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx		xxxxxxx
			(to child)
g	_____''''- - - - -		
D	shes really dictating the terms isnt she -----,-----,-----,		
P	-----,-----,-----,----- yeah I know - shes sleepin through		
g	- - - - - ....._____''''- - - - -		
	(to patient*)		(to child)
g	....._____''''- - - - -		
D	-----,-----,-----yeah-----yeah-----,-----,-----		
P	great I'm getting <u>my</u> sleep Steven is I get up at half eight .hh an then she		
g	- ....._____''''- - - - -		
			(to child)
m	xxxx		xxxx
	(points to self)		(points to child)

This example then shows how "facilitation" is a phenomenon embodied as much in movement as in speech. The next data (6.6) shows a doctor using a more questioning style, and shows the effect of this on the interaction.

#### Data extract 6.6 (Appendix 2)

Objects which function as questions are found in lines 5, 7, 11, 17, 19, and 22. They are followed by quite brief responses, and only at lines 8-10 does the mother offer anything like an account, and this does not follow a question, but is inserted over the doctor's identification of the patient. There are no "facilitatory" utterances, nor does the doctor convey the sense of wanting to hear more by his movement. In fact, the reverse, where he says (line 22) "I:: see so in fact when you're sort of moving then it hurts", he gestures to illustrate his meaning (6.6a)





Medical education has absorbed the "skills" of communication into most undergraduate teaching, but what may not yet have been appreciated is the extent to which the consultation is an internally engineered process, each action being both formed by prior actions, and forming the context for following acts. CA offers a new vocabulary for describing and appreciating these phenomena, which may enhance the already well-developed awareness of communication issues in medical education.

## CHAPTER 7: QUESTIONS AND REJECTIONS

**"Consultations are sometimes like conversions. At other times they resemble interrogations. But mostly they are somewhere in between."  
(Paul ten Have 1991)**

### **Introduction**

The medical interview has been categorized as an interactional setting in which "asymmetry" is normal (ten Have 1991). Ten Have reviews the evidence for "asymmetry", particularly in the senses of asymmetries of initiative, and of questioning, through doctors' characteristic use of the "third position"<sup>15</sup> in a sequence, and asserts that doctors (and patients) maintain the state of "asymmetry" in a number of different ways: by "monopolizing initiatives" and by "withholding information". He concludes that more research is needed to elucidate the ways in which patients try to influence the course of consultations, through their interaction with these asymmetry-maintaining behaviours.

It will be interesting also to draw on the findings reported in Sacks' paper "On the preferences for agreement and contiguity in sequences in conversation", delivered in 1973 and published posthumously from a tape recording made at the time (Sacks 1987). Sacks showed from a range of data, nineteen instances of unspecified origins, but described by him as "conversational materials", that a pattern exists of in-situ organisation of speech, such that second speakers prefer to agree with prior speakers' questions or statements, and that if they do, they express their agreement early in their turn. When second speakers do disagree, then they place their expression of

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<sup>15</sup> See glossary: the "third position" refers to the "adjacency pair" concept of Schegloff and Sacks (1973) in which for example a question followed by an answer is followed next by an expansion of the topic on which the original question was based.

disagreement later in their turn, prefacing it with a modified form of agreement. First speakers, if they sense that their co-participant is in disagreement, may use devices to change their proposition into one with which their co-participant can agree.

These phenomena also occur in my data, where the "stakes" for disagreement may be higher than in "ordinary" conversation, since there is a professional-client relationship, an asymmetry, which may lead to a patient from dispreferring disagreement even more than normally.

Frankel (1990) noted that patient-initiated utterances were rare in medical interviews (echoing West's (1984)) observations, and that when they did occur, they had the following characteristics:

1. sequentially modified questions: questions asked by patients preceded by a query or a noticing;
2. questions in response to solicits by doctors, warranting new information from the patient;
3. initiations at boundaries marked by announcements or interruptions;
4. initiations in the form of multicomponent answers.

[By "solicits", Frankel means either (a) a comment by the patient following a series of questions, such as "I want you to know everything"; (b) a direct solicit, as

Dr: There anything else y'wanna show me while yer in here.

Pt: =Uhm, (0.2) No but let me j'st ask you if y'think I have (.) va-a vaginal infection at all becuz- its- a l'l kinna so:re. Uh- An at- in a way that is doesn't ordinarily

or (c) patient initiations at boundaries marked by an announcement by the patient:

Dr: So this is the one an' I'm gunnuh write dat down.

Pt: Okay, .hhh let me just ask you one er two other questions

Dr: awright dat's disease//one]

Pt: Ok]a:y (0.3) So- wai- yer gunnuh write down ...

((continues with question))

Dr: Yep. ((telephone interruption))

(77.0)

((phone is hung up))

Pt: Now- you asked me 'bout the sleeping, (.)//uhm. I am a light sleeper

or (d) at boundaries marked by patients' interruptions:

Dr: Did y'feel sick  
(0.6)  
Pt: A little bit.//Ye:s]

Dr: Mmh hmh.] Right, .hh Now c'n yih// tell me-

Pt: An I wz very white  
(0.3)  
Dr: Pale?  
Pt: Pa:le

(Frankel 1990, p.244)]

I searched my data corpus for examples of patient actions which served as questions, collected them onto copy tapes, and transcribed a number of cases for further analysis. My first example (data extract 7.1, Appendix 2), taken from the series of general practice surgery consultations recorded in the author's practice, is between a GP (JH), a mother, and her child who has a discharging ear, and has previously had a surgical procedure in which a small plastic tube (a "grommet") is inserted into the ear drum.

#### Data extract 7.1 (Appendix 2)

5P\* c'n you see that n'there yeh?  
6D (yeh)  
(5.0)  
7D .hhh er actually (.) its just clear fluid that's coming  
8D out at the moment  
9P\* yeh

The patient-initiated question (line 5), "c'n you see that n'there yeah?", invites a response, but the doctor instead replies with a very soft "yeh" acknowledgement token, spoken while he continues to examine the child's ear. The next turn (l. 7-8) is held by the doctor, in other words the mother appears to relinquish her "right" to speak after the doctor's acknowledgement, associated with the doctor maintaining his attention on the examination. More detailed transcription (7.1a) allows us to see how the doctor achieved this "asymmetry".

## Transcript 7.1a

(looking into child's ear) (rotates child to see other ear)  
 gaze: \_\_\_\_\_/.....  
 D and the grommets working fine-----  
 P -----c'n you see that nthere=  
 gaze: \_\_\_\_\_  
 (at doctor)

(looking into other ear)  
 gaze: .....  
 D -----(yeh)-----  
 P =yeh?-----  
 gaze: \_\_\_\_\_  
 (at doctor)

The doctor, who is looking at the child while physically moving her into position to examine her other ear, addresses his gaze to the instrument to look into the ear immediately after the end of mother's question, while acknowledging it with a very peremptory "yeh" token. Thus the mother has no opportunity to fill her third turn, because the doctor has clearly cancelled any sense of reciprocity that may have existed as he was speaking, and rotating the child. The mother's question, "c'n you see that n'there yeh?" refers to the "grommet", and raises the question for an observer, what does she want to know about the grommet? The mother's responses to the doctor's comments as he examines the child's ear (lines 8, 12, 15) each acknowledge the utterance without adding to her expression of curiosity voiced in line 5. The doctor's gaze (transcript 7.1a) during her question, which continues to focus on the child's ear, fails to establish reciprocity at this point. Thus here, physical examination by a doctor creates a "don't interrupt, I'm busy" message for the mother, whose question is therefore not followed up.

West (1984) addressed the nature of "questions", (p 73-78), and concludes that for conversation analysis, the adjacency pair concept of Schegloff and Sacks (1973) provided an empirically grounded and reasonably general model. A question, if a first pair-part of an adjacency pair, is then an utterance which, in the context, anticipates an answer. It essentially looks forward, which distinguishes it from a second category of utterance, which may appear as a question, but which looks backwards, which West terms "quasi

question-types". These "conditionally relevant" questions either seek clarification of a prior utterance, or initiate a repair of an unclear element, or express surprise at what has been said.

It follows from this that some questions will not have the syntactical form of questions, yet will serve that function. The next example is one such. The extract, Transcript 7.2 (below), comes from a routine follow-up consultation between a GP and a retired policeman, who has a heart problem resulting in tiredness and breathlessness. The doctor completes an examination, then says there is not much he can do about the problem, and asks the patient how he feels about that.

**Transcript 7.2. (JHe)**

1P       Dunno. I've got to live with it. There's no arguing.  
 2\*       Unless they've got some miracle tablet down there?  
 3D       No, afraid not.  
 4P       No - I didn't think you would have.  
 5D       I mean it doesn't make any difference to your life  
 6       expectancy or anything like that. It just upsets  
 7       what you can do, and what you can't do.

The question, in line 2, ("unless they've got some miracle tablet down there?"), receives the short answer "no, afraid not", and is completed by an acknowledgement by the patient in line 4, making a completed sequence. It is a quasi-question type of West, looking back to the doctor's statement of prognosis, and not expecting a substantive answer, as the fourth turn (line 4) makes clear. The patient makes no attempt to explore the topic further, by asking a supplementary question, or offering an alternative answer. What appeared to be an example of a patient asking a question is, by this analysis, rather a patient confirming what he has already heard, and not seeking to pursue any disagreement with the doctor.

The next case (Data extract 7.3, Appendix 2) contains a question which appears to act as a request for action. A woman who has asked the doctor for "slimming pills" to help her reduce weight, is receiving a from the doctor her opinion of how weight loss should be achieved, having already refused to prescribe the slimming pills (lines 1-6).

At line 7, the patient asks to see the dietitian. The utterance, framed as a question, is acknowledged, but not followed up (line 8). There is an unintelligible patient utterance at line 9, then the doctor continues her account of her treatment plan. The request to see the dietitian is then put under scrutiny by the loud "IF YOU'RE SERIOUS". The doctor seems put out at having her advice challenged by the request to be referred to an "expert", and is momentarily put off her stride, seen in the one-second pause between lines 9 and 10. This doctor has set aside the question, returning to it later (line 13), and finally agreeing to the request at the end of the consultation (Transcript 7.6 line 7).

In a similar sequence, with a different doctor, a patient asks for vitamin tablets:

**Transcript 7.4 (JH2:)**

- 1P       d'you think I could have some vitamin tablets doctor Hough (0.5) or a tonic
- 2D       they don't actually do anything Mary just make sure you're eating well you get  
all the vitamins you need in an ordinary diet e::rm if you're not eating well  
then vitamins are not going to make the difference (.) the thing to do is get  
yourself sorted and start eating properly.  
((hands prescription))
- 3P       (right)
- 4D       now you want some things for George

Again, the request is acknowledged, here with an expansion of the reason for rejection, but with no opportunity for the patient to use her "third turn" (line 3) to return to the topic: the action of handing over the prescription, for items discussed earlier, signals the end of that topic, so all the patient can offer is a soft "right".

Returning to the "dietitian" case, further on in the consultation this patient asks another question which cuts across the doctor's train of thought (Transcript 7.5, Appendix 2). Here the patient's question asking for a diet sheet (line 6) is followed by a continued doctor turn (lines 7-14). There is a pause at the end of line 7, where the patient might have entered, but did not. When at line 17 she does ask for specific advice, the doctor retains her possession of the turn by interrupting, acknowledging, and resuming the





returning to school be harmful to her? The doctor answers "yes", and the mother responds "great" (l.7) and overlaps the doctor's "alright then" with "okay then thank you very much". Both doctor and mother behave as though they have reached the end of the consultation, by starting "closing" utterances. The mother's question appears to be of a sort that only expected a yes or no answer: she was not seeking detailed information, only permission to do what she already thought she would do. The question acted as a pre-closing device (Schegloff and Sacks 1973), in the light of following utterances. A doctor response of "what were you concerned about?" would clearly have led to a different sequence.

The same doctor, with a child with mumps, shows first a similar response to a mother's question, and then an atypical one (Transcript 7.8, Appendix 2). Here the question (lines 9 and 11) "It's okay he's not eating? he doesn't want no food" is answered at lines 10 and 12 with a long overlap with the second half of the question, leading straight in to an instruction of how to deal with the temperature, to which the doctor attributes the loss of appetite. The mother offers acknowledgement tokens (line 13) but no attempt to expand on her question about eating.

By contrast, in this final extract from the same consultation, (Transcript 7.9) the mother does achieve a "third turn" and this results in an explanation sensitive to her concerns (cf Tuckett et al 1985). The first question (line 5), is of the same sort as the question in line 3 of extract 5 (transcript 7.7 above). The reply too is brief and affirmative. Here however the mother follows with a second question (line 7-8), because her underlying worry is not her child's mumps, but the possibility of her husband catching it. The doctor (line 9) hesitates, before responding in some detail about the complications of mumps.

Thus in not all cases of patient-initiated questions do general practitioners in this data corpus inhibit patient's questions. However, when doctors do "reject" patients' ideas, the associated phenomena are particularly interesting. "Disagreement" as an activity excites the student of professional-client interactions because it embodies so explicitly the ebb and flow of argument, in a context where argument is unexpected. Coulter's (1990) study of argument sequences is relevant, not that he uses data from medical or other professional settings, but he offers an analytic framework which can be tested and applied to my data. "Arguments, or, minimally, disagreements between parties in talk",

form the substrate for an analysis of "an ordered optionality system". Coulter offers a crude structure of (1) declarative assertion, followed by (2) counter-assertion, expanding to: (1) declarative assertion, (2) disagreement, (3) solicit, and (4) counter-assertion.

I hope to show, from my medical data, a related phenomenon, "topic rejection", comprising the following four components:

1. a topic as defined by the patient incorporates a proposition which the doctor understands to be false;
2. the doctor refutes or rejects the offered topic;
3. patient acknowledges doctor's view;
4. patient adapts to doctor's view or restates the original topic.

**Data: extract 7.10 (Appendix 2)**

A mother has brought her teenage son, and the first topic is "his warts" (lines 2-10), but the second topic (Line 11) relates to his cold, which is the source of a disagreement.

**(1) definition of topic, and (2) re-definition (rejection) by the doctor:**

The patient's mother in line 11 asks for a "biotic" for her son's cold. The doctor counters with the statement "antibiotics won't get rid of cold", to which the mother responds immediately with an acknowledgement ("well"), and a re-defined statement of the problem, "could you give me something for he's aches and pains". The son uttered a series of unintelligible words, marked in the transcript as (...)(line 15), which his mother appears to interpret to the doctor by her statement "heez aches and pains he said".

This rejection of the initial topic, and its subsequent re-definition by both patient and doctor, contrasts with the opening of this consultation, where all three parties share the topic "warts", and, by their non-verbal behaviour, all three standing, looking at the son's hand, reinforce their agreement with the topic.

In Transcript 7.11 (Appendix 2) a patient offers the proposition (slightly indirectly) that tetanus is a problem acquired "abroad". The doctor, after commenting on the way he had "talked" the patient "into" the injection, is himself rejected by the patient's "I think

we're getting off course"! Thus the patient has raised the topic of travel abroad, and then dismissed it himself as irrelevant. The doctor, seeing, I surmise, an opportunity for "education" within the topic of tetanus prevention, firmly rejects the patient's statement that the conversation was getting off course, (oh no no) (line 7), and supplies his alternative view (line 10), that tetanus can be acquired anywhere. The patient's response to this is to acknowledge and amplify it (line 12). The topic, tetanus acquired abroad, is rejected and re-defined, and accepted by the patient.

In another example of rejection, (Transcript 7.12) a mother and child suffering from a discharging ear, this mother's proposition (l.6), that the ear was infected, based on her observation (l.5) that the ear was painful when she tried to clean it, is simply rejected in the next line, and followed by eleven seconds of silence when the doctor writes in the notes. His subsequent statement about the treatment is contingent upon his view that the ear is not infected, is accepted by the mother as she appears to continue the topic of the child's behaviour and the possible effect of the medicine. The defined problem, "I thought it might be infected or something", is rejected, but not re-defined. It is just ignored. The implications of such actions, where a doctor observably does not respond to a patient's request, idea, or proposition, are not clear, in CA terms. I have not analysed further these phenomena, but were the opportunity to arise, as I suggested in chapter 3, to record consultations which are routinely shorter than the average, it would allow further exploration of this question.

### Conclusion

Tuckett et al (1985) considered the extent to which doctors addressed patients' ideas, and tested hypotheses relating doctors' acceptance or rejection of patients' ideas to patients' understanding of and agreement with the diagnosis and treatment. Their work showed that there is a relationship between these variables, suggesting that the way doctors deal with the ideas patients have about their illness may influence the outcome of the consultation. When a doctor rejected or ignored a patient's ideas the patient was less likely to remember what was said about the illness or its treatment, than if the doctor did not reject or ignore.

This analysis show how doctors achieve "rejection" of patients' ideas, and suggests further avenues for research.

## CHAPTER 8: ON THE RIGHT TO SAY "WE"

### Introduction

"I believe that it is time to challenge the social arrogance expressed in the universal tendency to say "we", "us", and "our" when one has no business talking for anyone but oneself." (Spiegelberg, 1973)

Elias (1978) wrote of the personal pronouns, "The personal pronouns represent the elementary set of coordinates by which all human groupings or societies can be plotted out" (p.123). His essay on these interesting little words (I, you, me, he, she, us, we, they) is rooted in a constructivist paradigm, but provides an interesting "classical" starting point for this chapter, before it moves firmly into intersubjectivity and phenomenology. He argues that the personal pronouns show "mutual exclusiveness":

"However one uses it, "I" means "I", not "you".....and so on throughout the whole series";

and further that they exist in complementary pairs (I-you, he-she, I-we), and therefore that they hold, in themselves, elementary roles in defining the social world. (Watson 1987, p.263).

Just as Watson challenged this position, I hope to show that, at least for the pronoun "we", there are organisational and sequential mechanisms governing its occurrence in the interactions between doctors and patients which transcend and "absolute" significance the word might be expected to have.

Spiegelberg in his essay "On the right to say we" calls it "part of the arrogance of power", referring to a use of "we" which assumes without warrant the complicity of others in the speaker's thesis. In a linguistic analysis of "we-talk" he suggests a division into formal secondary uses of the pronoun: (1) the royal we, (2) the plural of modesty ("we humble sinners"), and (3) the editorial we; and the everyday literal uses of we, which are divided according to whether those considered by the speaker to be his partners are present (4) the "we of co-presence" or absent (5) the "absentee-we".

One question for a study of medical interviews is whether all doctors' uses of "we" fall into the latter group of literal uses, or are some examples the medical equivalent of the "royal we"? Thus "shall we have a look at your sore finger?" could either be construed as signifying that both parties are going to observe the inflamed appendage, (the we of co-presence), or that the doctor is using the word in some special way. When a doctor says "shall we have a listen to your chest?", the case for a special meaning becomes clearer<sup>14</sup>.

Spiegelberg concludes by analysing the various types of "right" to say "we", from a legal right, a logical right, an epistemological right, a linguistic right, to finally (and it seems for him most importantly), a moral right. He asserts that despite many valid objections to the use of "we", there is a case for its limited, and careful, use. It is with the *apparently* profligate and careless use of "we" by doctors in talking with patients that this chapter is concerned<sup>15</sup>.

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<sup>14</sup> There is an interesting instance of "we" as a problem in Sacks' own lectures, reported by Jefferson in Sacks (1992) pp 126-130.

<sup>15</sup> Despite my reference to "moral", and "careless", I should assert my acceptance of Garfinkel and Sacks' principle of "ethnomethodological indifference" (Garfinkel and Sacks 1970). They assert that "persons doing ethnomethodological studies can "care" no more or less about professional sociological reasoning than they can "care" about the practices of legal reasoning, conversational reasoning, divinational reasoning, psychiatric reasoning, and the rest." (p.346) The point is that ethnomethodology does not take a judgemental stance towards other methods of making sense of the world, but nor does it involve itself in them, because they cannot relate to the situated organisation of the formal structures of everyday activities. This does not preclude the analyst from making moral judgements from the conclusions of ethnomethodological studies, which is what I am doing here.

By serendipity rather than design I was introduced to the writings of Martin Buber, after discussing these ideas with a colleague. To cite a theologian in a work of "medical sociology" (if that is what this is) could appear strange. There are precedents: Weber (cited in Parsons 1968, p.516 ff.) wrote extensively on Calvin, while Sacks' own lectures are seasoned, lightly, I admit, with Biblical references and allusions<sup>16</sup>. Buber is interesting because he addresses the *relationship* which the words represent, and so approaches the spirit of CA, which also asserts that *words* are a way into what is happening in society.

### Martin Buber and the "I-you relationship".

In "Ich und Du", translated "I and Thou" (Buber, trans. Kaufmann, 1970), the theologian and philosopher Martin Buber argued that the relationship between two individuals varies qualitatively according to the concept the one has of the other. He coined the terms (translated "basic words") I-you, and I-it, to reflect two alternative sorts of relationship. He clearly valued the former above the latter, and proceeded later in the book to apply the I-you relationship to the theological concept of man's relationship to God. Buber had less to say about "we", but his translator, Kaufmann, commented:

"There are men who never speak a sentence of which I is lord, ... at the centre of their world is We. Theirs is a sheltered, childish world in which no individuality has yet emerged. Another perennial attitude is summed up in the words Us-Them. Here the world is divided in two:... the sheep and the goats."

This gloss on Buber leads to an exploration of the "We-you" relationship, where the "we" represents an immature perception of self, an unwillingness to express individuality, while holding an "us-them" view of the other, putting him into a different (perhaps inferior) group from me.

The substitution of "we" for "I" may, by this analysis, be a means of avoiding my intimate relationship with the other, converting him from a "you" ("du") into an "it", because a

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<sup>16</sup> See for example Sacks 1992 vol. 1, p. 121 (Adam), p. 397 (Abraham), p. 118 and 412 (Job), and vol.2 p.220 (Lot).



plural "we" cannot hold an close "I-you" relationship with another: that is the prerogative of "I". Buber emphasises this by referring to the reciprocity of the relationship:

"My You acts on me as I act on it. Our students teach us, our works form us."

If I am not alone, but am part of a group called "we", I cannot be affected in this way by You. It would be easy to over-apply Buber's thesis to the doctor-patient dyad, but at the epistemological level he has set out a point of view which emphasises the value of a one-to-one relationship. In the doctor-patient context, it could be that my relationship with my professional colleagues that constitute the "We" is more important than my relationship with You. In that case, it is only when I change my We to I in relation to You that I enter Buber's I-You relationship with a patient.



Fig 1

Figure 1 illustrates the way that "I <---> You" is a reciprocal relationship, while "We-->You", and its source term "I---->It" are one-way expressions that operate at unequal levels.

If I-Thou-ness is important in the construction of a relationship, as opposed to I-It, Us-them, or We-you, then conversation analysis will provide empirical evidence for the natural occurrence of these phenomena, and their contexts.

### Schutz and the "we-relation"

This is the subject of the paper "The dimensions of the social world", reproduced in Schutz (1964)(pp.20-63) where Schutz develops his theory of intersubjectivity. In Schutz' terms, a "pure" we-relation is one where both members of a relationship are fully "thou-

orientated" (cf Buber's I-thou). He calls this the "pure we". The "concrete we-relation" is the actual level at which such interactions occur. Schutz' "ideal types" of relationship are less helpful in the present context, as they are derived from theory, not the real world. We (by which I mean I, and each reader of this text) can recognise in the "pure we-relation" a form of interaction against which to compare what we notice in the data.

#### Sacks' analysis of "we".

I came upon Harvey Sacks' lectures after completing my own analysis of doctors' use of "we", and so was especially delighted to find that the primogenitor of conversation analysis had addressed the subject. Sacks explored the use of "we" first in his lectures (Sacks 1992) in Lecture 3 of Fall '65, where he presents an eight-minute excerpt from a teenage group therapy session, comprising the therapist, and three regular members and one new member of the group. The relevant data is:

Th: Henry  
 Henry: hi  
 Bob: hi  
 Th: Bob Reed  
 Joe: (cough) We were in an automobile discussion,  
 Henry: discussing the psychological motives for  
 Mel: drag racing on the streets.  
 (Sacks 1992 p.136)

#### Sacks comments that:

"An extremely sharp formulation is made of the term "we" where it remains the subject of a sentence without each person affiliating himself to it."<sup>17</sup>

He continues, "Is it the case that "we" is some collection of these guys' names, directly? ..... Do we have to build a category here?" (op. cit. vol 1, p.148).

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<sup>17</sup> Sacks' use of the word "formulation" here seems distinct from the later, specific sense defined by Garfinkel and Sacks (1970, p.351): "We shall speak of conversationalists' practices of saying-in-so-many-words-what-we-are-doing as *formulating*."

Now Sacks systematized his ideas on "categories" in the paper "An initial investigation of the usability of conversational data for doing sociology" (Sacks 1972) (one of the few formal published works he produced before his untimely death in 1975). Among other concepts, this formulated the "population-adequate membership categorization device"<sup>18</sup>, which excludes no members of a given population, and is not ambiguous. Also the "consistency rule", which states that the same device may be used on all members of a population, and the "economy rule", whereby it is possible (though not mandatory) to categorise all members of a population by applying only one category to each member. Sacks concludes that:

"we" can (though need not necessarily) refer to a category which has a some of its crucial properties that no intention exists of listing its incumbents, and furthermore they are not listable"

In a later lecture (Lecture 8, Spring '67) now famously titled "Everyone has to lie" (Sacks 1975) he began the analysis of the warrantability of the truthfulness of members statements, as in "How are you?" "I'm fine". This led on to a consideration of the formula "Y do X", as in "Women are fickle", which returned Sacks to the question what do people mean when they say "We"? Since Y is here a categorical, it may not be necessary for a member speaking of "we" and referring to that category, to be actually present in that category in the sense of doing what is said. For example, I, a supporter of Liverpool Football Club, might well say "We are playing at home tonight", without, in any sense, playing football! I believe a similar analysis is taking place in my exploration of doctors' use of "we".

Doctors, in common with other professional groups, seem to use the expression "we" in place of "I" when the context implies a professional opinion. How they are using this categorical device, and how it relates to the idea of "I-thou-ness" is the object of this study. Since I shall be making frequent reference to the "meaning" of the term "we", I must address the problem of knowing the "literal meaning" of a word, in relation to its contextual meaning. A full discussion of these issues is beyond the scope of this thesis,

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<sup>18</sup>where a "categorization device consists of a list or collection of categories plus rules for their application.

but Heritage and Atkinson's footnote (1984 p. 13-14, note 3) outlines the arguments, and gives references.

**DATA** (which for this chapter is all included in the text).

All examples of "we" and related expressions encountered during the scanning of this corpus of data were systematically extracted onto a copy tape, and salient sections transcribed and notated using varying levels of complexity of the system devised by Gail Jefferson and others (see appendix 1). In the analysis I shall first examine doctors' utterances of "we", and then patients'.

I tried to approach the data with an open mind, but took the categories used by Spiegelberg as a starting point. In Spiegelberg's terms, doctors appear to use "we" both to express co-presence, professional corporateness without presence, and also a sort of "royal we".

### 1. The "We of co-presence".

#### 8.1 JHa 1:5 Extract (i) (TAPE sequence 5, 120 - 132)

D       so really:: I think we should just wait and see what the  
D       next ultrasound shows  
(0.5)  
P       yes (1.0) well when he said to me I'll see you=  
P       =in about four months I assumed it was an ultrascan

Doctor and patient are included in the doctor's "I think" decision: the doctor as the speaker of the "we", and the patient, because he acknowledges the doctor's meaning by referring to his understanding of what the hospital specialist had said at his previous visit ("I assumed it was an ultrascan").

#### Extract 8.2 (SMel 4:5)

D       they haven't actually done what we asked them to do have they  
       why don't you have it out with them next time ( )  
       just say (.) look (.) me and my doctor think you ought to do patch testing

This extract makes explicit the we of co-presence in relation to a hospital specialist, when he advises the patient to say at her next meeting with the consultant: "Me and my doctor think you ought to do patch testing"! It should be noted however that this doctor was highly atypical in his style of consulting, and use of language, falling at the extreme "patient-centred" end of the spectrum of Byrne and Long (1976).

The next fragment is from the same doctor. Co-presence is even more clearly apparent in consultations which address patients' feelings.

### 8.3: (data fragment SMel 2:1) (f):

D: I suppose the real question that we've skirted to some extent is what we're going to do about your feelings

The entire consultation from which this extract is drawn lasted 26 minutes and was conducted in a "reflective" counselling style, in which this statement was entirely consistent. The patient's feelings were the legitimate object for shared consideration and management by the two of them. "We" here clearly means "you and me", "I and thou".

The next data comes from a consultation between Dr PK and two people, the man being the "patient", who has a chest complaint, for which he had seen another doctor a few days before. That doctor had given the patient a piece of paper, bearing the instructions for taking the treatment he had prescribed. The consultation centres on the number of tablets to be taken ("three at present"). In this fragment there are three "we's" (lines 1, 3, and 4) and the extent of co-presence of less clear. In his response, Dr K employs "we" three times, each time directing his gaze away from the patient (see transcript 8.4b with gaze).

### 8.4 a (PK 6)

10\* so we've reached the the three at present

2P yes

30\* right okay (0.5) good so it sounds a'we probably have a listen to your chest (0.5)

40\* probably sounds as if we need to:: up the (0.4)

50 er dose back up again for a longer time

(1.0)

60 what provoked it this time?

8.4b (gaze added)

(Asterisks here show where gaze is at the medical records, rather than the note brought by the patient: see text.)

	*(at note)	(to records)*
G	-----	
D	so we've reached the the three at present----right okay-----	
P	-----yes-----	

	*(to note)	*(to records)
G	-----	
D	good so it sounds a'we probably have a listen to your chest	

	(to patient)
G	-----''''-----
D	-----probably sounds as if we need to:: up the-----er dose

	* (to records)
G	-----''''-----
D	back up again for a longer time-----what provoked it

In the first instance, (line 1), he appears to be reading from the patient's note, confirming the present state of affairs that the patient and his medical advisors have reached. That the patient is included in this "we" is confirmed by the response "yes" from the patient. In the next phrase the doctor's "we" seems to be the subject of the verb "have a listen", an activity in which the patient can hardly share, since he is himself, or rather his chest, the object of the listening. Throughout this utterance the doctor's gaze is away from the patient, directed at the note, apart from a brief (0.5 second) glance at the medical record on the desk. "We", the actor of the proposed action, is supported by visual association with other doctors, in the written note of current treatment, and the medical records. It is a "corporate professional we". (see next section).

Co-recipienty with the patient is maintained by a glance (0.3 second) at the word "to:", followed by a return to the records, then another rather longer patient glance (2.5 secs), at "er dose back up again for a " before again returning gaze to the medical record.

**Data extract 8.5a (90 seconds after 8.4)**

1D I think we should put you back on to an: antibiotic and up the: dose of=  
 2D prednisolone (0.5) yes? er::m and I would think we should put you on to  
 3D eight a day (0.5) and er:: I think I'd like to see::

**Transcript 8.5b (gaze added)**

g ----- ''-----''-----  
 D I think we should put you back on to an: antibiotic and up the:  
 g ----- ''-----''-----  
 D dose of prednisolone-----yes? er::m and I would think we should  
 g ----- ''-----''-----  
 D put you on to eight a day-----and er:: I think I'd like to see::

The ambiguity of the use of "we" is shown in extract 8.5, which occurred after the doctor had completed the examination, and had returned to his desk, and the patient was moving back to his seat. On the basis of "listening to the chest", the doctor delivers his decision, that "we should ....", the same expression being repeated (lines 1 and 2). On both occasions he speaks while looking at the medical record, while moving his gaze to the patient shortly afterwards. It could be inferred that the "we should" is associated with other doctors, some of whom have written in the records, while the details of the instructions are personalised, by the gaze to the patient, accompanied by the seeking agreement "yes?" (line 2).

As a device for reducing the impersonality of this corporate medical we, this doctor, (and many others in the data), uses the construction "I think we should" (lines 1 and 2). Other examples from this corpus of data include (i) line 1, and (iv) line 11-12, and the following other extracts:

"I suggest we do nothing further"  
 "I don't think we should"  
 "I think we ought to"  
 "I think we need to"  
 "I think we'd better start an antibiotic"  
 "I think we'll need to think about referring you".  
 "I think we'll have your kidneys x-rayed".

The alternative construction, "I think I should..." appears very rarely in this data, although more direct "I" phrases are quite common.

Since writing the first version of this chapter I have been "sensitized" to the phenomenon, and have noted its occurrences in other CA literature. It is not inappropriate to cite published examples from within CA (Psathas 1990b p.8) where they add to the richness of the data, or build on the argument. There follows an extract from Sharrock and Anderson's (1987) paper on "Work flow in a paediatric clinic", from a data extract which represents the opening of a consultation between a doctor and a mother with an infant.

#### Data extract 8.6

1.15D: And you were also thinking of starting the immunisations  
 1.16M: Yes  
 1.17D: I see - OK ((1.00)) right - well let's start we'll do the er- have a look at  
 him first  
 1.18M: Mmm  
 2.1D: And then we'll think about the immunisations  
 ((14.00))  
 Any problems at all  
 2.2M: -Yes- you know he's sweating a lot.....

I am interested in the "we" at line 2.1, but also at line 1.17, and the preceding "you" in line 1.15. By establishing that the mother had been thinking about the immunizations, the doctor can include her in the "we" of co-presence in line 2.1. Sharrock and Anderson suggest that the mother's silence at line 2.1, a 14 second pause which, from my data and



others, is too long to be unoccupied by some activity, but what activity the published transcript does not indicate. This "we" is again, ambiguous.

## 2. The "absentee" or "professional" we.

This was found frequently in the data, used to express either an intention to carry out some test or investigation, or to initiate treatment, eg.:

(MD 2:1)

"I think we should send you over for a test to be absolutely sure"

(SM 1:7)

"We'll give you some paracetamol too".

It is linguistically and logically inconsistent for the same individual to be simultaneously both the subject of and the object of the verb "to send". I may be able to give myself some medicine, but to "send myself" makes nonsense. The "we" cannot here include the patient.

In the case of the doctor speaking to a mother about her child, as in SM 4:5, "we'll give him some simple penicillin", it is possible that the mother is part of the "we", sharing in the act of "giving" penicillin to the child, but the similarity between the use of the expression "we'll give" in doctor-adult patient and doctor-child-parent contexts suggests that the meaning in both is the same: some corporate professional activity. This might be considered, in Spiegelberg's terms an example of the "absentee we", but it is hard to conceive precisely who the absent others are. The act of prescribing is essentially an individual act: while the pharmacist who dispenses the prescription is involved to some extent, it is a subordinate involvement. The decision to prescribe is the doctor's, unless he deliberately shares it with the patient. As I have already shown, the patient is usually excluded from the "we" by being the object of the act. In the same way, the use of "we" by the doctor about to examine a patient is unlikely to include the patient. A similar conclusion is reached by Nijhof (1989) in his "text-sociological" analysis of the medical model, when he observes a doctor's utterance (transcribed without the detail of CA):

Dr: No, its nothing to do with that. You've had a termination and this can cause prematurity, and we look to see if the womb is opening up. If it is, we put a stitch in.

Within his analytical paradigm, which is by no means consistent with CA, but shares some of its underlying assumptions, the use of "we" by a single doctor is seen as evidence that a socially constructed medical model exists. The same speaker's previous turn was:

"I don't care a damn what the doctor promised last time. If you lose the baby its up to you. Do you know why we do these examinations?"

This corresponds with my frequently observed "I think we will....", the doctor using "I" to represent truly personal activity, and "we" to represent his "professional" activity.

#### Extract 8.7 (PK4:3) (simplified)

1P I come back with a cough at the time quite a few people had it  
 2P we just put it down to being at altitude for so long  
 (1.0)  
 3D yeah=  
 4P dry air and er but progressively got worse and has gone to my chest now  
 :  
 :  
 5D sounds as if you've got a chest infection (.) I think we'll have a listen  
 6D to your chest  
 :  
 :  
 7D hop over to the couch anyway and lets have a listen shall we?  
 8P yes  
 ((moves to couch))

It is unlikely that the doctor means that both he and the patient will listen to the patient's chest, but neither does it seem that he is giving a professional judgement. Is this rather an example of the formal, "royal" we? How it is perceived by the co-participant can be at least inferred from the reply "yes": this seems a routine form of speech. It may be that the patient understands the "we" to refer to both doctor and

patient, since the immediate next action involves them both, the movement to the couch. However, I do not accept this explanation entirely. It is not impossible for a doctor to share with a patient the activity of physical examination: in a remarkable example in this data, a doctor having listened to a child's abdomen through his stethoscope, passed the stethoscope to the child's mother with the words "have a listen", to which the mother, having listened, says "ooo yes, sounds like Vesuvius!". The same doctor in fragment SMel 4:5 makes explicit his use of "we" in communicating a shared opinion to a hospital specialist. However, I emphasise that this behaviour is extremely uncommon!

### 3. "We" as a professional strategy for coping with embarrassment:

The form "let's have a look (listen, feel) ", applied to a part of the body about to be examined is a common variant of the professional "royal" we. It could be argued that it represents a comfortable colloquialism, designed to reassure an anxious patient that what is about to happen is an everyday occurrence, of the same order as a flat tyre, a jammed window, or a faulty piece of equipment, where in each case the appropriate artisan might say, "let's have a look then, shall we?". On the other hand, such a construction serves to professionalise, and to some extent de-personalise the doctor, protecting him from the possible embarrassment of an intimate examination<sup>19</sup>.

In another sense the "professional we" serves to de-personalise the patient, in Buber's terms creating an I-It relationship, which would equally serve to re-define behaviour that in other contexts would be intimate. Emerson comments:

"This indignity can be cancelled or at least qualified by simultaneously acknowledging the patient as a person." (Emerson 1970).

Interestingly, Heath (1984) showed that the non-verbal behaviour of patients during physical examination by a doctor was typically to look into the middle distance, neither at the doctor, nor at the part being examined. For the duration of the examination, the

---

<sup>19</sup> Joan Emerson's (1970) study of gynaecological examinations, while it does not explicitly address this use of language, does emphasise the collusion within the team which protects doctors from becoming intimately involved in a potentially embarrassing situation.

patient "became" an object. "Let's have a look", with its overtones of the mechanic, supports that analysis. Doctors may be aware that patients adopt "impersonal" behaviour during examination, and adjust their form of speech accordingly.

**"We" and gaze: some evidence for embarrassment-avoidance.**

This example shows a doctor with a child of about 8 years, and her mother, addressing a problem with the child's ear. This doctor uses "I" rather than the professional "we" in most of his talk with patients, but that is unusual in my data.

**8.8 (SM1:2) (Doctor with mother M and child) (Gaze added)**

```

                                     (to child)**
                                     ((smiles))
G  -----
D  any coughin?-----mm hm Can I have a listen in ----- Vicky -----
M  -----yes she's had um-----°listen
G  -----
                                     .....
                                     (to child)

                                     ((picks up stethoscope)) (gaze at child)
G  ----- / / -----
D  -----(chw chw chw)(1.0) ears are okay and throat's basically okay and at the
M  to your chest-----
G  ----- / / -----

                                     (to mother)**
G  -----
D  moment::: I'm thinking typical just a sort of virus cough and cold sort of thing.
M  -----
G  -----
                                     (from child to doctor)
    
```

When the doctor adopts the alternative construction of "I", the personal form of speech is accompanied by eye-contact (\*\*).

By contrast, transcript 8.9 shows a doctor using the "we" form when initiating an examination, and avoiding eye-contact during this utterance, briefly flitting to the patient during her very apologetic and defensive comment that her notes were as thick as a novel. (His reply of "I've seen thicker" seems to me not to adequately address her feelings at that point.)

8.9 (GP 7:2) (Woman with back pain, and a "thick folder" of notes)

((at medical notes))

g ----- .....  
D shall we just have a look at it then-----  
P ----- .hhh sa Barbara Cartland novel that one isnt it  
g -----

((to medical notes))

((at medical notes))

g -----  
D ----- hhhhhh hh I've seen thicker  
P hhh .hh sthick as one-----  
g -----

// (9.0 seconds)

((points to couch)) ((at desk))

g .....  
D go stand by the couch and we'll just have a look at your back-----  
P ----- right  
g .....  
((at couch))

On the other hand, when the physical examination depends intimately on the patient's interpretation of that examination, eg "show me where it hurts, now tell me if this hurts, if I press there, does it hurt?", "we" constructions are absent.

## 4. "We" as a strategy for justifying professional action:

Data: extract 8.10 (below).

This is full of references to the anonymous professionals: "somebody" will look inside his bladder, in the same way as "they" did before, "we" should refer you back. The patient is not silent, but several times interjects assent. Does this mean he associates himself with the "we"? Again, "we should refer you" makes it impossible for the patient, who is the "you", to also be part of the "we". This is the "professional we", where the absentee members are other doctors, either in the practice, or simply part of the profession.

## 8.10 (PK 1:5)(Man with blood in his urine.)

1D u:m if::: that was the case then I think we'd probably have to refer you back up to  
 2D let somebody else have a look again in the same way as they did with that telescope  
 3P yeah yeh [ ] ] no  
 4D yeah? I wouldn't think we need to do that at this stage (0.5) as this is just=  
 5D the first episode that you've had and its got better so quickly but if you find=  
 6D that you get another episode where you've got blood in your water  
 7P yeh  
 8D e::r and where::: you're passing clots then I think: you should come back and I=  
 9D think that we should refer you for somebody to have a look in and see how it gets  
 10P [ mmm  
 11D =on  
 12P oh yes

The distinction between this "we of professional activity", and the doctors' perceptions of themselves as individuals is illustrated by the common combination of "I think we", as in "I think if we give you some pain-killers" (PK 5:7), "I think we should just wait and see" (JH 1:5), or "I think you should come back and we should refer you" (PK 1:5). There are no instances in my data of a doctor saying "we think"!

In PK 4:4, the doctor combines the "I think" construction with the "we of professional activity":

"I think you've got a chest infection down that side so if we put you onto an antibiotic..."

Now the process of putting this patient "onto an antibiotic" comprises first the doctor writing out a prescription form, handing it to the patient, who takes it to a chemist to have the medicine dispensed, then himself takes the medicine for the prescribed time. Thus at least three people are involved in the total act: can they be the subjects of the "we of medical action"? The patient logically cannot, as he is the object of the action ("we put you onto an antibiotic"), so can the chemist be the absentee component? The phrase means, "if we, your doctor and your local chemist, put you onto an antibiotic". The problem with this interpretation lies both in the impersonality of the chemist, any chemist could dispense the prescription; and in the passivity of the chemist's role, chemists simply carry out doctors' instructions (the prescription form consists of a series of commands, in latin "recipe", "signe", and "mitte"<sup>20</sup>). Further, in this example the doctor seeks the patient's assent ("alright?") after outlining the proposed treatment course, implying that he alone had the power to initiate or alter the plan.

If the use of "we" in prescribing treatment is ambiguous, its use in initiating investigations is more easily seen in terms of an absentee we, since the test is performed by another professional, either a doctor or a technician, (eg "the urine test we did", PK 1:1), but again, it is the act of initiating the test which may be referred to, as in "we should send you over for a test" (MD 2:1), where the object is the patient, and the "we" can only logically be referring to the doctor.

This "we of professional activity", occurring in the one-to-one consultation, more than "softening" the utterance (Sacks) seems to also distance the speaker from the closest involvement with the patient.

---

<sup>20</sup> Meaning "take" (ingredients), "write" (instructions), and "send" (quantity).

5. Patients' use of "we" (See transcript 8.7 above.)

P I come back with a cough (.) at the time quite a few people had it we just put it down to being at altitude for so long

This young man, who had just returned from a trekking holiday in Nepal, describes how he and his fellow travellers had made sense of a particular symptom, the cough, which several of them had suffered. "We" here refers to the absent group, either all the party, or those who had experienced the cough, including himself. This use of the "absentee-we" is found in medical dialogue either when there are more than one "sufferer", as here, or when the speaker has shared their experience with another (absent) person, such as a spouse, and reports their joint opinions or actions.

Thus (SMEL 2:1):

Mother: "we tried the fluids, but it didn't work",

this from a mother describing the efforts of herself and her husband to deal with their child's diarrhoea. In GP 4:1 (a mother consulting with her child who has an ear infection), the mother says,

M "we keep it dry because we know if he gets water in it it gets prone to infection"

This is probably another case of the "absentee-we", where the absentee is the other parent, although an argument exists for the child being the co-present member. Whichever it is, it is followed by the doctor's statement,

D "We'll have to give him some antibiotics for it", (GP 4:3).

This doctor used both "I" statements for prescribing, and "we" statements, apparently indiscriminately.



## 6. Discussion.

"We-expressions" are widely employed by doctors in their everyday speech with patients in the consultation. I have categorised them into (1) "co-presence", (2) "absentee", and (3) "professional", where the former two are as described by Spiegelberg, and the last may be a variant of what he describes as the "royal" or "editorial" we.

There seems to be no particular problem with the first of these: indeed, when the doctor by his use of "we" is demonstrating a shared approach to the medical task, this might, in the light of Tuckett's (1985) work, contribute to more effective consultation outcomes.

The second, "absentee-we", in which the doctor implies that others, unspecified, and often unidentifiable, are involved in the action, is problematic insofar as it dilutes the doctor's responsibility, and could confuse the patient's perception of who is involved in their care. ("Come back and see us in a week; we will arrange an appointment; our usual advice to you is...") This interpretation was corroborated by one of the doctors participating in the video data, who when asked for his interpretation of his use of "we", replied in terms of the group practice, team approach, wanting to show patients that both (or all) the doctors in the practice were involved in their care.

But the third category, the "we of professional activity", poses a major problem, if it represents the doctor's assumption of the role of "mouthpiece", or "agent" for the medical profession. Issues of power and control are immediately raised, where by invoking a body of special knowledge, from which the patient is excluded, the doctor creates or maintains the "asymmetry of the consultation" (Heath 1986). I have shown examples, which are not isolated, of the association between this form of words and gaze non-recipienty. Within my data, different doctors appear to use the form to different degrees, so Drs GP and PK used it a lot, Drs MD and JH less, but the numbers of consultations from each is probably too small to be certain, and in any case, this analysis is not concerned with numbers! (Garfinkel and Sacks 1970).

Watson (1987) discusses the shortcomings of grammatical models of "pro-terms", in particular those of Pike (1973) and Lowe (1969) who refers to "ambiguities such as the inclusive use of We", and argues that conversation analysis offers a far more appropriate framework for the explication of the use of these forms within the whole structure of

interactional talk. He develops the term "organisational" as a qualifier for "We", corresponding closely to my "professional we", with similar data examples.

### **7. Conclusion:**

Spiegelberg set himself three objectives, the first I quoted at the start of this chapter ("to challenge the social arrogance.... when one has no business talking for anyone but oneself"); the second was to refute a perceived antagonism between linguistic philosophy and phenomenology; but the third is most relevant to this thesis:

"initiate the exploration of a basic concept in the social sciences which, to the best of my knowledge, has not yet been tackled: the linguistic meaning of the personal pronoun "we" and the structure of the phenomenon that corresponds to it." (op. cit. p.130).

I have tried to continue his task. My conclusion thus far is that "we" is extensively used by doctors in place of "I", and that this substitution, while sometimes ambiguous, often represents a degree of distancing in the doctor-patient relationship, greater than the doctor might recognise, or even wish to be the case.

## CHAPTER 9: CONCLUSION

"On structures in medical interaction" has been an empirical study of the work of general practitioners in everyday practice in the UK. I have taken the observable actions people in the context of general practice consultations, and analyzed them through the paradigm of conversation analysis. There have been other such studies in the same context, notably by Heath (1986), ten Have (1989, 1991), and Frankel (1989, 1990), and my first conclusion must be that my findings broadly concur with those previous works. I think my analysis of "by the way" on closing (chapter 3) adds to what has gone before, and builds on the important early non-CA work of Byrne and Long (1976).

During the time this work was in progress, the "computerization" of British general practice had been going apace, such that by 1994 most practices had some form of computer system in place, and about half had computer systems being used *in the consultation*. The general implication of my findings in chapter 4 are no less valid for this, since whatever the medium, any visible record will *interact* with participants in a consultation when it has relevance for either or both parties, as here. Some work has already been done on the computer record, and more is in progress. CA has shown its power as an analytic tool to explicate the complex three-way activity between doctor, patient, and computer (screen and keyboard)(Greatbach et al 1993).

My exploration of treatment talk (chapter 5) has led me to appreciate further the importance of the "prescribing phase" of a consultation in creating an *environment for talking*. This is ironic, since for general practitioners of the more "doctor-centred"

tradition (of Byrne and Long), handing over a prescription is often seen as a sign of dismissal! If the point at which the doctor ceases to write (or type) is a candidate invitation to the patient to talk about whatever has been concerning them, and which they have been "saving up" until that moment arrives, it would be clinically helpful for doctors in practice to be aware of this, and even to actively invite comments and questions at that point in the consultation.

"Communication skills teaching" has become fashionable in Medical Schools and for postgraduates in general practice, and recently in hospital specialities also (Myerscough 1992, Pendleton et al 1984). The chapter on "Facilitation?" has shown that the mere display of what might be labelled "facilitatory" utterances on the basis of their lexical type and placement in the interaction is not necessarily facilitatory, in the sense of enabling the other to say more. Much more salient is an understanding of "intersubjectivity", in Schutz' sense. (This might, in another analytic world-view, be called an enabling "attitude", although I fully realise that this term is highly problematic, and therefore prefer always to work in the CA world-view, and work with objects I can see and hear!)

The ultimate caricature of a "bad" doctor could be typified by the sentence: " I ask the questions", spoken to a patient who dared to voice a doubt or query. Like all caricatures it is not so far from reality, and its corollary, that "good" doctors allow patients to ask questions, is also observably true. The limited evidence in chapter 7 around this phenomenon suggests that in the sequential organization of talk in the consultation, asking questions is a "dispreferred action" by patients, and when they do it, they are likely to not achieve a full discussion of their topic. The comments on the implications of the chapter on facilitation apply equally here.

"On the right to say "we"" asks whether this common pronoun has any "sequential implicitiveness" for the interaction in which it occurs. I argue that it does, and that it also depends on what has gone before, verbal and non-verbal. The chapter again raises the issue of intersubjectivity, and how the two (or more) participants in a consultation show their awareness of and orientation to each other. This phenomenon, or class of phenomena, is of critical importance for health practitioners of whatever sort, who may have learned particular ways of doing their work from teachers who did not appreciate the importance of "intersubjectivity", and its concrete outworkings in "doing interactions"

(a subset of Sacks' "doing being ordinary"). Thus students, medical, nursing, allied professionals, may learn to interview using "open questions", to explain things in a structured way, and to enquire for patients' ideas (Myerscough 1989), but unless they appreciate how in the course of the interaction, co-participants change their activities according to what the other is doing, and how their activities profoundly influence those of their patients, they will not be able to make the best use of the "consultation", that central source of health work (Spence 1960).

Throughout the work I have taken for granted the methodological basis of CA, albeit having sketched its origins in chapter 1. The relationship between CA and other sociologies remains problematical, but from my perspective as a newcomer to sociology, and a sometime practitioner of other "sciences", for example, physiology, pharmacology, and even statistics, in "clinical trials" (Heather et al 1987), I find CA to be both illuminative and rigorous in its ability to address fundamental issues in human interaction. Sharrock and Anderson (1987b) point out that one problem is the reluctance of traditional sociology to accept a new paradigm.

"In order to open up to investigation the organisation of commonplace activities one needs a new framework, for the conduct of enquiries into social order conventionally depends upon taking these things as given, the accepted form of enquiry *requires* (sic.) that these issues be treated as givens." (Sharrock and Anderson 1987, op. cit. p.295).

Sharrock and Anderson's apologia is directed at criticism of CA from "discourse analysis" in particular, yet it meets a more general critique that CA is unsystematic, and un-focused. It seems to me that CA has, in recent years, moved away from the purely "random" studies of conversation, to look at more context-driven problems, such as those presented here. If the methodology is valid for "conversation", it should be valid for other modes of interpersonal interactions: indeed the present bibliography includes many such studies.

I acknowledge however the profound importance of the underlying theory, that conversation is a "self-explicating system" (Pollner 1979 cited by Sharrock and Anderson), which depends on "the observable artful practices" of its actors.

My interest has been in the "conversations" between doctors and patients, known as "consultations". I hope that this work, constructed out of the detailed scrutiny of video-taped consultations, will shed some light on that thing, that "meeting between experts" (Tuckett 1985), "on which the whole practice of medicine depends"(Spence, op.cit.).

The end

## **APPENDIX 1: TRANSCRIPTION CONVENTIONS**

### **Introduction:**

The data for any Conversation Analysis study comprises primarily the electronic recording of whatever form, in the case of this work, video-tape. The principle that any such material is available to fellow investigators for confirmation or disagreement of the analyses has been set out by others (Heath 1986, Sacks 1992)

Transcription of recorded data has been the method of choice for "capturing" the data, both to allow the more systematic analysis of the data by inspection of pages of text, and by observation of sequentially set out talk with time and overlaps notated.

Gail Jefferson is credited with the development of the system which has become widely used, with various modifications, in most CA, since the early work of Sacks, with whom Jefferson worked as "data retrieval technician", and collaborator. Conventions for non-lexical components of speech are drawn from Heath (1986), who in turn drew on Goodwin (1981), and Kendon (1982).

Reproduction of spatial aspects of interaction, which are well captured by video-recording, is problematic. Heath discussed the problems, and after considering the constraints of confidentiality, chose to use line drawings in his book, which was concerned very substantially with movement in interaction. These drawings, made from Polaroid "stills", taken from the video monitor, represent one solution, but probably rely heavily on good descriptive writing in the accompanying text. I have preferred to use







1D Hello (1.5) come in (4.0) Im doctor MacDonald  
 2P (Yes:)  
 (2.0)  
 3D (What can I do for you)  
 4P E::hm (1.0) I seem to be gettin these (.) pains and like palpitations  
 5D (2.0) ((nods))

Here the "s" at the end of "yes" is extended (as might alternatively be written "yess"), and the "ehm" utterance (line 4) is prolonged in the vowel component, rather than the final "m". Writing this "eehm" would convey a different sound in english, so the colon provides a neutral extender of whichever syllable it follows.

The stop, comma, and question mark, at the end of any part of an utterance, do not refer to sentence structure, but to tone of voice: thus the stop indicates a stopping fall in tone, a comma a continuing tone, and a question mark a rising tone.

6 J itching?  
 7 P yeah  
 6D when did you notice it first.  
 7P eh when I wuz (.) away.

(These have been used sparingly in this work, because there has been little reference to them in analysis.)

A dash immediately after an utterance shows an abrupt cutoff, while underlining indicates emphasis:

14D how- how is it all going  
 15P no- very good actually  
 16D not very good.



Other activities are added in a second (or third) line of symbols, usually with the letter "m" in the margin to indicate movement, but also with annotation to describe what they signify. The symbols used to represent movement vary, for example in the following, a row of "x" is used, but elsewhere asterisks, or continuous lines convey the presence of an activity, the nature of which is always made clear in the text and in a note on the transcript.

```

      ((moves sideways towards door))          ((finger movements))
m  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx  xxxxxxxxxxxxxxxxxxxxxxx
P  -----
D  well we'll just wait and see - a::nd ----- you know if youve got anything else
g  -----
    
```

Here, two different movements are transcribed, the patient's move to the door, and then the movement of his finger. The patient's gaze is not transcribed here because it was not possible from the video-recording to establish it: he had his back to the camera as he left the room.

**Other conventions**

Sometimes lines are omitted from a transcript, when this is shown by vertical dots, and a note.

Arrows or asterisks may be used to mark objects of interest which are then referred to in the text.

In general, it is important to re-emphasise that the data comprises the recordings, not the transcripts. Transcripts are devices for (a) sharing the data easily with larger numbers of colleagues that could access the tapes, and (b) exposing features within the data that might be obscured by the activity on the tape, by allowing the separation of each speakers' activity.

## **APPENDIX 2: DATA EXTRACTS**



## (2.1 cont.)

- 24P and it was all in me head like but I dont know whether thats got anything=  
 25P to do with it or not I- .hhhh  
 (0.6)
- 26D we:ll lets look at any other possibilities?  
 (0.2)
- 27D ha- have you been quite healthy.
- 28P yeah yeah I'm full of cold but I mean,  
 29D mmm (.) when did that start.  
 30P which me cold? erm well its catarrh really I've got you know=  
 31D [ cold [ yes
- 32P e:rm its all in me head whether tha- thats got anything to do with it?  
 33D ye:s
- 34P but I mean I do suffer with catarrh but not dizzy spells.  
 (0.2)
- 35D NO: .hhhh
- 36P I bet you'll have a good laugh over this with that camera dont yer? hhchou hhh  
 37D no: actually- (1.5) we're not going to look at it its its something very=  
 38P [ no [ just
- 39D =special about erm its a research  
 (0.8)
- 40P °yeh
- 41D study where we're (just) going to  
 (0.6)
- 42D look at (0.4) we're actually hhchh its about looking at=  
 43D =what computers do so we're going to look at it again when we've=  
 44P [ mmm
- 45D =got a computer on the desk but erm ther ( ) dont worry  
 46P [ mmhm [ I think that mmhehehemmmhehem
- 47P .hhhh
- 48D and we'll be looking at us really not- not at the patient its really how we're  
 49P i- it's your reaction (0.2) yeah.  
 50D °what we're doing°
- 51P yeah yeah
- 52D erm you've been very healthy haven't you,

(B) DATA EXTRACTS FOR CHAPTER 3

DATA EXTRACT 3.1:

End of Cons: (starts 8 min 54 secs into consultation.)

JH;TC 02:18:14

- 1D So erm let me see you again sometime after Christmas?
- 2D (.) alright? (.5) and er we'll see how it goes from there
- 3P right
- 4D ahm and really carry on as you're going (.5) e::rm  
[
- 5P right then
- 6D I think (.7) m:maybe that you'll get some more (.) episodes
- 7D such as you describe but if they all settle themselves down  
[
- 8P oh well
- 9D as quickly as (nothing) too bothered about  
[ [
- 10P is normal like to have
- 11D it does happen like this yes yes
- 12P kind of attacks like this (.5) its nothing really=  
not at all  
[ ]
- 13D =serious then (not at all) its so I feel alright in=  
=myself I can erm (1.0) work about like I do get tired=
- 15P =quicker than what I did so I mean=  
[ ]
- 16D Yeh I should think that's true
- 17P =I've been doing a bit of decorating at home last week or so=  
=but .hhhh where I could paper a wall so've in a day=  
20D mmm (0.5)
- 21P its took me about three days I get really tired=  
[ ]
- 22D mmm mmm



(3.1 cont.)

23P =quickly (1.0) and (.5) thats where I notice the shortness of=  
[  
24D mmm

25P =temper I think (.) a piece of paper won't go straight

26D yeah  
(0.5)

27P get annoyed with it (1.0) want to screw it up straight away  
(0.5)

28D but not the price it costs for a roll of paper  
[  
29P ( ( ))((laughs)) even better wouldn' it  
(0.5)

30D okay

31P Oh er::m  
[

32D see you sometime after Christmas and the New Year

33P e::rm early in the new year?

34D yeah lovely okay. bye bye now

35P bye bye. ((leaves))

**DATA EXTRACT 3.2 (Diseng. Frags. 012-035)**  
 (patient, young man, had consulted about pain in the chest)

- 1P ((moves to door))
- 2D Well we'll just have to wait and see (.) a::nd (0.5) you know if you've
- 3D got anything else that worries you in the meantime come back and we'll
- 4D check you over
- 5P [ yeah (0.5) I te- som'n that 'as been worryin me bo-  
 (0.9)
- 6P is of a night e::r I can't seem to sleep  
 (2.0)
- 7P but a lot of things run though me mind
- 8D [ mmmmm?  
 (3.0)
- 8P (I was just)I put it down to the anxiety I put everything down=
- 9P to the anxiety (I didn't) think er so much could be involved in it
- 10D [ yes
- 11D yes but its only at night when youre completely on your own  
 (0.6)
- 12D that: you dont have to concentrate on anything else that you  
 (0.5)
- 13D you do think about them
- 14P [ things run through your mind
- 15D the things that are really bothering you
- 16P ye::ah
- 17D that doesn't surprise me at all
- 18P heh he he
- 19D mm
- 20P .HHHHH
- 21D I'm sure mister Davis will help you
- 22P o:kay thank you
- 23D (okay) (0.5) bye for now.

DATA EXTRACT 3.3 (Dr JH, Mr L) (PHD1EXT5)

(4.0)

1 D Right do you want erm need some more of your tablets

2 P No I'm alright for tablets

3 D [ you're alright for tablets (.) did you get some

4 P I got some sort of in between seeing you last time

5 D [ Ah right

6 P er just a sick note please now if you would

(3.0)

7 D well come and erm (1.0) see us again in three months

8 D unless you're running into problems

9 P right okay

10 D alright if youre running into problems you know where to come

11 P °ri::ght

(13.9) ((Dr writes certificate))

12 D what'll usually be six months?

13 P (.) no f- usually give me three  
\*\*\*\*\*  
((\*phone rings))

14 D three months

15 P (but e::r) .hhhh

16 P if er:::(1.5)if its easier for you to make it three months=

17 D [ oh no make it six

18 P =it doesn't make any difference to me

(17. secs) ((Dr continues to write cert.))

19 D °right there you are (3.0) dont er don't worry

20 D about what I've just told you its not er

21 P [ no

(3.0)

22 P (okay)

23 D Ohhh

24 P I'm not the worrying type anyway so er

25 D [ no I know you're not

26 D °I know youre not° but er sometimes you know can er

(3.0)

23 P (well)

(3.3 cont.)

(1.0)

24 D get fed up about that

(4.0)

25 P (I find plenty) to take my mind off it

26 D [ .mhhh hhhh

(1.0)

27 P thanks very much

28 D I think that's the right attitude that

29 P we::ll there's no good doing much else? is there

30 D no (.5) theres nothing you can do=

31 D =about it so you might as well

32 P [ I dont think there is anyway

(2.0)

33 P bit of a fatalist in that respect

34 P (.) heh heh heh

34 D [ right cheers

35 P [ bye bye

(1.5)

36 D oh have a nice christmas cos I wont see you till after prob//ably

37 P righto thanks same to you

38 D che::ers

39 P cheers

((Dr turns to desk and writes, pt has left room.))

Duration of extract 1 min 36 secs.

Total length of consultation seven minutes and six seconds.

**DATA EXTRACT 4.1 (Dr DO'B)(Lady with sore throat)**

((knock at door))

1D HELLO

(2.5) ((door opens))

2P °good morning do-°

3D Hi::

4P good morning

(3.8)

5D so how are you (2.2) how are you

6P ((sits down)) [ still got this::

7P (kinda) feeling doctor  
(tender)

8D yeah

(0.8) ((doctor sits down))

9P a the back a me thro- you know

10P me throats:: er (0.4) seems all choked up

**DATA EXTRACT 4.2 (same patient, later in same consultation)**

1D lets have a look inside

2D I hope you haven't got any thrush back again

3P No:: (0.5) its just erm

4D ((turns page of notes)) I checked your urine before didn I

5P an I went for me blood test but i'wasnt through

(2.5)

6D ((searches notes))

7D well we've had yeah we've had e:rm

(5.0)

8D ((shuffles through notes))

9D erm (2.0)

10D bu- w: a blood test you had on the fifteenth

11P [ at Sefton (.) yes

12D e::r tha- that was ner:normal

**DATA EXTRACT 4.3**

1D Good morning (6.0)  
((puts previous records away, and picks up other from desk))  
2 Giselle Shepherd  
3P mmhm  
4D I'm doctor Murphy (0.5) I don't think we've met before  
5P no we haven't

**DATA EXTRACT 4.5 (Second consultation for cough)**

1D Hi: Mister Jones (.) com'n an sit down there  
2P [ hello [ right  
(3.0)  
3D Are things improving?  
4P I think a little bit of pain is gone from this chest  
5D ri:ght but it is er improving a bit  
6P yeh but erm ((shakes head)) not right  
7D well thats all but so long as theyre gradually getting better  
8P these er pains its not (.) anywhere near you know  
9D mmhm  
10P its its pratically gone  
11D what about the phlegm from your chest now  
12P I still get'n the green up  
13D are you  
14P yeah  
15D yeah  
16P I finished them course of (.) tablets today  
17D ri::ght  
18P erm tha the red  
(0.8)  
19D yes the capsules  
20P [ and the white ones

**DATA EXTRACT 4.6 (Young woman requesting repeat prescription for the Pill)**

1P ((knocks on door))  
 2D hello:: (2.0) (hello)  
 3P Hi doctor  
 4D hi ((flicks over notes))  
 5P (gonna be on telly)  
 6D sorry?  
 7P Y' goin to be on the telly  
 8D Thats ri::ght  
 9P No its not the baby (.) its only e:rm I only really  
 10P wanted a checkup you know I need a (0.5) me pill=  
 11D [ hhhhhh  
 12D =ri::ght  
 12P [ prescription and I wondered if you would take me blood=  
 13P =pressure for me  
 14D I will yeh yeh  
 15P [ ]  
 be great::

**DATA EXTRACT 4.7**

1D ((spends 11 seconds reading notes, then goes to door))  
 2D Hi Missus Browning  
 3P (mmhm) (3.2)  
 4P °(I just wanted to get back to work)  
 5D I suspected thats why you were coming to me  
 (2.0)  
 6P Ive still got this terrible cough but I want to go in  
 7D yeah (0.5) are you under any pressure from work (0.5)  
 8D I mean are they putting pressure on you to get back  
 9P O (.) g: very short  
 10D mmm (2.6) If they weren't so short would you stay out=  
 11D =fer the fer the other week  
 12P yes

**DATA EXTRACT 4.8**

1D ((reads notes for 7 seconds, stands up still reading for further 4 seconds))  
 2P ((knocks on door))  
 3D HELLO (1.5)((pt enters)) hello:  
 4P hello.  
 (2.0)((shuts door))  
 5D ALL THE BLOOD TESTS WERE NORMAL  
 6P °okay thats very nice thats marvelous isnt it  
 7D ((sits down)) well I wasnt too worried I know you had a lot of bruising  
 8D an that but some people just bruise easily  
 9P easily yeah  
 [ ]  
 10D yeah

**DATA EXTRACT 4.9 (New patient)**

1D (9.0)((thumbing through casenotes))  
 2P ((knocks on door))  
 3D HELLO:  
 4P (morning doc)  
 5D Oh good morning missus Campbell  
 6P yes  
 7D never met you before missus Campbell  
 8P no I y havent doctor  
 9D I'm doctor Murphy  
 10P unfortunately the er doctor=  
 11D =Hough=  
 12P =is away er  
 12D ye:s he usually sees you  
 13P yes yes me erm Ive only come for a note actually  
 [ ]  
 14D ye::s  
 15D ri::ght  
 16P just e::r um as(0.5) just an ordinary sick note

[DATA EXTRACT 4.10 in text of Ch. 4]



**DATA EXTRACT 4.11 (also 6.4)**

1D Hello (1.5) come in ( ) (4.0) I'm doctor MacDonald

2P (Yes:)

(2.0)

3D (What can I do for you)

4P E::hm (1.0) I seem to be gettin these (.) pains and like palpitations

5D (2.0) ((nods))

6P duuno what its with

7D ri::ght (0.8) how longs this been going on for now

(1.6) ((reading notes))

8P e::rm (4.0) Wednesday evenin it started

(1.8) ((Dr reading notes))

9D and what happens: (.) exactly

## Data Extracts for Chapter 5, Treatment talk.

## DATA EXTRACT 5.1 (SMel 1)

(\* = start of writing \*\*\* = stops writing)

1D fine I think we'll give her some er  
(0.5)((picks up pen))

2D can you take penicillin

3P ye::s  
\*

4D ahha I'll give her some of the famous amoxil okay

5P yes (2. ) right hhaha  
(2.0)

6D mmm well the reason I've chosen that is they do a sugar=  
\*\*\*

7D =free version of it

8P oh do they really  
[ \*

9D yeah yeah

10P well that's advancement isnt it

11D well funnily enough its a growing trend (.) you're for ever  
\*\*\*

12D shoving medicines into children if you give it last thing

13D at night you know they've got sugar on their teeth all night

14P yes yes  
[\* ]

15D I think its sa:: mmm  
(2.5)

16D youre ten arent you

17P mm she is  
(6.0)

18D .hhh  
[

19P we keep expecting it to go in the next day or so and=  
=when (.) when it doesn't well

20P

21D Yeah  
((signs prescription with flourish))

(5.1 cont.)

22P I think its time to do something

23D I think its started off as a viral thing and its got a  
\*\*\* ((stamps date))  
((tears off prescription))  
xxxxxx

24D bit of secondary infection which has (2.0) fairly=  
25P =is it contagious or anything=  
[ ]  
26D common around

27D =its an infectious disease

28D I wouldnt say it was contagious though

29P no no

30D if you know what I mean

31P no

32D erm do you mean about school

33P ye:s

34D what do you think ((hands prescription to mother))

(1m 12 secs from start of extract)

## DATA EXTRACT 5.2 (DO'B 22.1.90)

1D Well I'll give you some antibiotics that wont upset  
 2D your tummy or are very unlikely to upset your=  
     [  
 3P hhhhhh  
 4D =erythromycin is (.) notorious:=  
 5P =oh it was (.2) dreadful.  
     [  
 6D (causing) upset tummies yea::h.  
 (0.6)

7D .hhh erm I I I Ive had so many bad  
     [  
 8P (oh) I couldn eat for the rest of the times=  
 9P =anyway for me throat (.) er it just-  
     [  
 10D ye::s.  
 11D Well Ive had so many bad experiences with it I I tend not=  
 12D =to use it any more (myself)  
 (1.0)

13D it can make people very (.) very sick,  
 (1.9)

14D .hhh erm (0.4) so lets hope you can get a (.) a proper course of=  
 15D =antibiotics this time (0.4) .hhh get rid of it,  
     [  
 16P mmmm  
 (6.5)((writes prescription))

17D are you still taking the pill or not.  
 ((still writing))

18P yeh.  
 19D °you know the (0.2) advice (.) when on antibiotics,  
 20D taking the pill do you?°  
 21P yeh hhhhh  
     [  
 22D yeh  
 (6.9)((still writing))

23P\* °.hh for how long?°  
 24D well really while youre taking them an an erm //e- er  
 25P\* //and afterwards as well?  
 26D no::w there shouldn't be any problem after that

## DATA EXTRACT 5.3 (J Ker Comp-2; 25.5.90) (Extract 1)

- 1D With you the way you are at the moment actually youre bringing a lot of this stuff up and you have been for a while I will give you a short course of antibiotics
- 2P okay
- 3D okay (1.0) right  
(1.0) ((gets prescription pad out of drawer))
- 4D d'you want ter (.) have a chat with the girls at the desk
- 5D about this: stop smoking course  
.  
.  
.  
.
- 13D theres lots of plus points for us as well  
(0.5)
- 14D twenty five a day you spend
- 15P a lot of money
- 16D seven hundred pounds a year?  
[
- 17P\* well (.) can I just interrupt doctor
- 18P my wife (.5) she smokes but (.) she doesn't inhale  
\*
- ((doctor turns to desk, and starts to write at \*))
- 19P she gets a cigarette and just goes phh
- 20D ((writing presription))
- 21P and puts it out (.) she smokes twenty-five a day (.)=  
[ ]
- 22D yeah
- 23P =so you can imagine the the cigarette bill
- 24D well not just I mean even though she does that shes still
- 25D inhaling it from the atmosphere around her all the time  
[ ] [ ]
- 26P is she yeh thas right
- 27P thas right true .hhhhh and (.) destroys the curtains
- 28P when I clean the inside windows,
- 29P 's a hell of a job,
- 30P .hhhh because its (.) as you say the bloom is (.) you know
- 31D °yeah° so the two of you together
- 32P thats right  
[
- 33D do you want to go back and have a chat with her? about// it
- 34P //ce- certainly yeh wha (be casing er) the cou:rs

(5.3 cont.)

35D well yeah the two of you together would be a lot easier  
[ ]  
36P yeah  
37D >if I can get the wife< yeah hhhe she works at Mossley  
38P if I can get the wife yeh (.5)  
39P Hill Hospital so as regards the times would this be  
40P an evening thing?  
(pauses from writing: gaze to pt.)  
41D they'll be able to tell you about it at the desk  
42P I see yeah yeah  
(4.0)\* [Dr completes writing prescription, and hands it to pt]  
43D okay so its one tablet three times a day  
44P one three times a day (.) as from now  
45D yes when you pick it up  
46P got to go to a chemist with this  
47D yeah  
48P Okay doc  
49D okay  
50P thanks very much (.5) and you byee  
[ ] [ ]  
51D nice to meet you  
52D cherybye  
(Ends)

[Data extracts 5.4, 5.5, and 5.6 in text]

## DATA EXTRACTS for Chapter 6, Facilitation?.

## Data extract 6.1 (MacDonald 1) (Adolescent boy and mother.) From start of consultation.

(M=mother; P=boy; D=doctor)  
 ((door opens))

1M Its er eez (0.5) got a lump (.) on his left breast (1.0) >yeah iz left breast  
 tha one

2D ri::ght=

3M =(just beneath the nipple)

4D ri::ght

[  
 5M ( ) the nipple

[  
 6D when did you notice it first.

7P eh when I wuz (.) away.

8M he was down at his er (.5) brother down at Fleetwood.

9D ri:ght

10M for a week for his holidays and when his brother (.) brought=

11M ='im back he said he::s got a lump

(0.7)

12D ri::ght (1.2) (erm) has it been sore at all

13P yes

14D (it has) right (.)

15D any discharge or anything like that from it

:

((few more questions))

:

:

((examines chest))

22D right this is a totally harmless er lump

23D its erm the male has a small amount of breast tissue

24D er which er at the time of puberty or just after erm

25D sometimes expands as the hormones are sorting themselves out

26D thats whats happening here (.5) hhh the breast tissues just

27D enlarged slightly its going to shrink away as mysteriously

28D as its come may last there for a month or two

29D it'l fade away

## (6.1 cont.)

30P e::rm it doesnt ( )

31D you can do theres noth- no treatment for it

32D its just a case of waiting and watching for it to disappear

33D itself which its going to do but the important thing is to

34D be reassured that theres nothing er=

35M =it does seem strange because Ive had a lump behind my ear

36M since I was thirteen

37D behind your ear

38M [ the doctor told yeah beh er this doctor told my mother

39M it would disappear when I finish (apparently)=

40M =an Ive still got it

41D behind your ear

42M yeah and Ive still got it there ((laughter))

43M since doctor ( ) said it would disappear heh heh

44D [ alright [ alright

45D I wouldn't know about that(.5) but certainly because

46D because the breasts are very sensitive to the hormones

47D they can respond to changes in them at the time of puberty

(0.2)

48D (thats what it is) (1.0) you feeling alright otherwise=

49D =in yourself (.)

50P er

51D ri:ght

52P [ ye::s

53D I mean if it hasnt faded in a month or two Id be glad to (0.5)

54D er check it over again for you

55M I we keep an eye on it I just dont like lumps

56M like that come up ( )

57D right

58M okay thanks doctor tarra

((6.42 ends))

[Data extract 6.2 in text]



**DATA EXTRACT 6.3 PC.1 ( Transition from "service delivery for asthma" to "troubles-telling")**

1D Have a seat (0.5) I'm doctor Williams  
2P thankyou  
3D Mrs Brown  
4P yes  
5D °havent seen you before have I°  
6P I think you have for a while ago actually  
(0.8)  
7D what's the trouble.  
8P I've actually come fer erm (.) an inhaler  
9D ri:ght °right ye:s°  
[ ]  
10P e:::rm (0.8) I just need a new inhaler (.) actually  
11D .hhh well (.) the asthma's quite new? isnt it for you?  
12P yeah just a couple of months ago  
[ ]  
13D yes:  
14D how- how is it all going  
15P no- very good actually  
16D not very good.  
17P ((shakes head))  
18D mm  
19P I have this brown one  
(0.8)  
20D yes  
21P when doctor Harris first put me on it  
22D yes  
23P ee gave it me to take er two puffs morning and night  
24D yes  
25P and erm when I come back to see him (.) he asked me to blow into the thing  
26P and it wasnt really much better than when he got called out to me  
27D mm  
28P so he put me on two puffs or a hundred instead of fifty  
29D right-  
30P .hhh so (.) and the blue one if necessary  
31D yes

## (6.3 cont.)

((44 seconds from start))

:

48 seconds of talk by patient, interspersed in the same way by "yes" (7), "mmm" (6), or "sure" (2) from the doctor

:

((92 seconds from start))

- 58D a- are there any other times when it seems to get you particularly.
- 59P well I've just lost me father in law actually an when 'e was ill an (0.7)
- 60D [ mm [ mmm
- 61P we watched 'im die in Sunnybank an I felt .hhhhhh you know a tightness=
- 62D [ tch mmm
- 63D =ye::s
- 64P [ but I think (.) you get that dont you whe- when ye:r (0.2) upset an (0.4)
- 65P that so I have had it so maybe all thats had something to do with it cos I
- 66D [ (you:)you can yeah ]
- 67P was very close to 'im you know?
- 68D [ ye:s ye:s=
- 69P =so 'e only got buried on Friday
- 70D °ri:ght°
- 71P but er (0.4) its just tha' ((holds chest)) just don't feel like (.) ri::ght
- 72D no ( )
- 73P [ since erm (0.4) >as I say I'm on this< (.) inhaler
- 74D ye:s
- 75P twice a day but I tend to as I say try not to take the blue one (.) unless=
- 76P =I really feel it necessary?
- 77D I'LL CHECK YOUR ERM FLOW WITH THE MACHI:NE and erm then I'll I'll
- (1.2)
- 78D t- well I'll tell you then whether you can increase it.
- 79D .hhh do you get any trouble in the ni::ght.
- 80P No.

((2 minutes 44 secs from start))

## DATA EXTRACT 6.4 (Facil frag 208)

((Knock at door))

1D Hello (1.5) come in ( ) (4.0) I'm doctor MacDonald

2P (Yes:)

(2.0)

3D (What can I do for you)

4P\* E::hm (1.0) I seem to be gettin these (.) pains and like palpitations

5D (2.0) ((nods))

6P duuno what its with

7D ri::ght (0.8) how longs this been going on for now

(1.6) ((reading notes))

8P e::rm (4.0) Wednesday evenin it started

(1.8) ((Dr reading notes))

9D and what happens: (.) exactly

10P its not the pain so much (.) the pain was on Wednesday (.) an its like a flutter

11D mmm

12P an a quick (1.8) e-er like a panicky feeling

13D [ mmm

14P\* but I didnt have a pain yesterday just had all like this:: (1.3) an I was cryin an everything (1.0) feels as though everythings gettin on top of me

15D oh dear

(0.5)

16P mm

17D so anything going on that,

18P well Ive just lost me mum (1.2) e::rm seven weeks ago found her (.) (dead at the bottom of the stairs)

19D I see::

20P and then (1.2) e::r ten days ago me eldest brother had a stroke

(1.8)

21D mm

22P I duuno whether thats all

(1.2)

23D was this all out of the blue that that happened

24P ye:s

25D ri::ght so you had no (.) warning that anything was

**(6.4 cont.)**

26P     no  
          (1.3)

27D     mm  
          (2.4)

28P     erm: (.) shoutin at the kids all the time an

29D     mm::

30P\*    I just feel as though me nerves are all on edge  
          (1.0)

31D     mm::  
          (1.6)

32P     Im goin to blow up at any minute  
          ((continues))

## DATA EXTRACT 6.5 DB 29/1/90 (Facil. Frags 660)

((Mother with baby, came for repeat prescription of the "pill": the doctor starts with blood pressure check. As the doctor completes the blood pressure reading, he comments on the reading.))

- 1D Thats fine.
- 2P its okay?
- 3D ye::s its normal
- 4P [ I thought it might have been up a little bit
- 5D oh right
- 6P me heads been aching a litle bit I don' know whether its=
- 7P =the baby pullin me hair all the time or no'?
- 8D wh is that what she's doin?
- 9P\* oh yeh 'fore she'll go off to sleep,
- (1.0)
- 10P an I was talking to Cerrie on Wednesday.
- 11D [ so what's the-
- 12D (0.4)whats the routine at bedtime then
- 13P (0.5) eh:: oh go:d
- 14D d'ye have to d'ye have to lie with her?
- 15P yeah (0.4) she doesnt go up till about eleven o'clock.
- 16D .hhhh shes really dictating the terms isnt she.
- 17P\* yeah (.) I know shes sleepin through great=
- 18P =Im getting my sleep and Steven is I get up at half eight=
- 19D [ yeah [ yeah
- 20P =an then she doesnt get up until about after nine,
- 21D mmm
- 22P so at least I know Im getting my sleep.
- 23D ye::s ye::s
- 24P [ but you know you see some babies go to bed about=
- 25P half six or seven o'clock: (.) god bless sometimes like=
- 26P =she's she's havin a little sleep and she hasnt even had her tea yet,
- 27D mmm
- 28P if I try to regulate her tea so she has it about say five=
- 29P =half five something like that.
- 30D mmm (.)
- 31P but shes shes wide awake shes active as anything,

**(6.5 cont.)**

320 mmm

33P she only went off at quarter past eleven last night finally got her off.

34D yeah

## DATA EXTRACT 6.6 ML 16/1/90 ((Mother, small child, and older child Paul.))

(D=doctor; M=mother; P=Paul)

- 1D Hello (1.5) hello come in and have a seat  
[ ]
- 2P hello
- (3.2)
- 3D Hi::  
[ ]
- 4M Oooh I could string him up heh heh
- 5D\* Who him or him
- 6M No him ((points to younger child))
- 7D\* Him okay whos the patient Paul right  
[ ]
- 8M I came with Paul because hes had a pain=  
[ ]
- 9M =since since he got up this morning so we sent him to school=  
[ ]
- 10M (1.0) but hes still n'agony with the pain
- 11D\* pain whe::re.
- 12M like to show him Paul  
[ ]
- 13P in my si::de (1.4) all there (0.5) hu:rts yeah  
[ ]
- 14D all round there
- 15P na mornin it was bad so (I was comin here) was in me kidney?
- 16P somewhere (in) me kidney?  
[ ]
- 17D\* ri::ght (0.6)is it there all the time or does it come and go?
- 18P it comes and goes:: mm.
- 19D\* what brings it on what makes it worse?  
[ ]
- 20P erm like sometimes=  
[ ]
- 21P =when I sit like that (.)its hurting when I get up an aah
- 22D\* I:: see so in fact if youre sort of moving then it hurts  
[ ]
- 23P so yeah hurts

**Data for Chapter 7: "Patient initiated questions and rejections".**

**DATA EXTRACT 7.1 JH 1**

1D      Well  
          ((examines child's ear))  
          (7.0)

2D      that ones actually okay=  
                                  [  
3M                                yeah

4D      =and the grommets working fine  
          (.5)

5P\*     c'n you see that n'there yeh?

6D      (yeh)  
          (5.0)

7D      .hhh er actually (.) its just clear fluid that's coming  
8D      out at the moment

9P\*     yeh  
          (3.5)

10D     and its actually coming through the grommet so that's  
11D     working alright  
                                  [  
12P\*                                mmm  
          (4.0)

13D     .hhh erm (.2) I don't think its worthwhile using an  
14D     antibiotic for this=  
                                  [  
15P\*                                yeh

16D     =er because the stuff that's coming through is quite clear

**[Data extract 7.2 in text]**



## DATA EXTRACT 7.3 (SC. 1 Extr. 1)

1D People lose weight if they cut down on their eating and  
 2D the::y e::rm exercise (.) yeah an it does=  
     [            ]  
 3P exercise  
 4D =its its a healthy way of doing it  
 5P mmm  
 6D its e:rm (.5) the body benefits  
     [  
 7P\* could I see the dietician again then?  
 8D CERTAINLY yeh absolutely  
     [  
 9P (             )  
 (1.0)  
 10D .hhh basically what I usually do is try an (.)put people=  
 11D =on the right tracks (.) and then get them to come and=  
     [  
 12P yeah  
 13D =see the dietician (.5) IF YOU'RE SERIOUS=  
     [  
 14P yes I wouldn't mind  
 15P =I am serious oh yes definitely serious  
     [  
 16D you'll do it without tablets=  
 17D =and you'll feel much better for it  
     [  
 18P better for it yeah

[Data extract 7.4 in text]

DATA EXTRACT 7.5 (SC 1, Extr. 2)

1D the more roughage you have the more you get rid of by the  
2D natural way okay (0.5) yeah=  
3P [ right oh yeh?  
4D if you eat more fibre it binds the fat in your bowel=  
5D =and gets rid of it  
6P\* Do you have erm (1.0) sheets or anything ?  
7D The dietician will give you that (.5) erm (.) so (.)  
8D what I usually recommend (.5) is (1.0) for your breakfast  
9D a piece of wholemeal toast (.) with thinly spread with=  
10P [ mm  
11D =a low fat spread (0.7) and some fruit (0.5) okay  
12D half a grapefruit or (0.5) some orange juice orange  
13D juice but orange juice is quite there quite a lot of  
14D calories in orange juice  
15P [ ye::ah better with the grapefruit aren't yer  
16D yeah (0.5) the grapefruit  
(0.8)  
17P\* I mean can you put bit of erm (0.5) is that canderel no'=  
18P =any good yerknow tha that sweetener  
19D [ Yes: that's very good yeah=  
20D =.hhh O::R (0.5) s:s a small couple of weetabix  
21D weetabix are filling (0.5) and low in calories  
22P\* they low in calories? I didn't know that  
23D some skimmed milk (.) and canderel

**DATA EXTRACT 7.6. (SC1, Extr 3)**

1D and then if you do a bit of exercise each day=  
[  
2P yeah  
3D =a good walk or a swim or something  
4P\* is swimming good for you yeah?  
5D yeah (1.0) brilliant  
6P\* I'll have to try that then  
7D will you make an appointment on the way out to see the=  
[  
8P I would  
9D =dietician I'm sorry I was I know it seems cruel  
[  
10P WELL THANKS FOR YOUR HELP NOW

[Data extract 7.7 in text]

**DATA EXTRACT 7.8 (ML-6: Child age 5 with mother (M))**

1D The things to look out for are if he becomes very very  
2D ill in himself I mean if he becomes a burning high  
3D temperature or becomes drowsy or goes completely off his  
4D food or off his drink and doesn't want to know then  
5D thats the time when we need to see him again but  
6D generally as I say they just get a high temperature which  
7D lasts for two or three days  
8D and then settles okay  
[  
9M\* yeah its okay that he's not eating?  
10D yeah he wont he wont he wont because he's got the=  
[  
11M he doesn't want no food  
12D =temperature at the moment=  
[ [ ]  
13M yeah yeah  
14D =all you can do at the moment is keep giving him the  
15D calpol alright (.) and if he's hot then you know he can  
[  
16M yeah  
17D take his clothes of and sponge him down a bit  
18M yeah  
19D er (.) wi the calpol a teaspoon every four hours



DATA EXTRACT 7.10 (Tape D O'B 23/1/90)

(Mother (M) and teenage son (S))

1D Hi:::

2M its his wa::rts (.5)

3D yeah

4M you told me to come back

5D ahh

6M six months ago e::r

7D theyre no better are they=  
[

8M six weeks ago

9S =no I got more

10M they've all spread'n on his fingers

11M\* an could you give im some biotics eez full o cold  
(1.0)

12D well antibiotics wont get rid of cold  
[

13S (....)

14M well could you give me s:something for=  
[

15S (...)

16M =heez aches and pains he said

17D I'll give you something to take to to ,make you feel=  
[

18D =a bit more comfortable yeah hhh erm  
((9.0 writing notes))

19D have you been continuing to go to to school

20S well yeah I carried on yeah  
[

21M he went to school yeah well he only got it on monday(0.5)

22M he caught it off me you see

23D ri::ght (1.5) well take a couple of these up to four

24D times a day and at least they'll take away the aches and

25D pains and that and make you feel more comfortable

**DATA EXTRACT 7.11; (Extract 3, adult male who had been bitten by a dog, and attended for a tetanus injection).**

1D you probably havent had a tetanus shot for years have you

2P no I havent no::

3D so you should have a full course then

4P oh god ha ha ha I havent been abroad for ages

5D I talked you nicely into that one didn't I

6P h::e you did hhh (1.0) I think we're getting off course

7D oh no no you dont need to go abroad to get tetanus

8P I think that's the last time I=

9D =erm yeah I mean that might be a time when you get them

10D but but the risks of getting tetanus are every bit as

(1.0)

11D as real here as

12P yes it could happen to you in the home

13D yes and gardening especially

**DATA EXTRACT 7.12 (Tape JH 25/1/91)**  
**(Extract 4 Mother and child with discharging ear.)**

((Dr writing notes))

1D       okay so we'll give you some medicine shall we  
2       shes not complaining of any pain or anything like that  
3M       no  
4D       fine  
5M\*      just when you touch it there yknow when I been tryin to clean er  
          (6.0) ((Dr writing in notes))  
6M\*      (I thought it might have been infected or somethin but)  
7D       eh it du it doesnt look it  
          (11.0) ((Dr writing in notes))  
8D       Ill give yo::u a a good large bottle of it an I'd like  
9D       you to u::se (0.5) one spoonful three times a day  
10M      yeah  
11D      erm (.5) shouldnt be any side effects with it  
12D      occasionally with children it can make them sort of a  
13D      little bit agitated e::r but erm its its its rare but  
14D      just keep an eye out for if she starts behaving oddly  
15M      she does that anyway

**APPENDIX 3**

**Consent forms**



PARK ROAD GROUP PRACTICE

Today your doctor's surgery is being video-recorded for medical research and teaching.

We will only do this with your permission, and we will not mind if you don't wish to be recorded.

If you are willing for your consultation to be recorded please sign this consent form and hand it back to the receptionist. If you do not want to be recorded please tell the receptionist, and return the form unsigned.

---

CONSENT FORM

Name J. Mosc .....

(to be completed by receptionist)

I am willing for my consultation with the doctor to be video-recorded for research and teaching purposes only.

I understand that I am free to withdraw this consent after the consultation if I change my mind.

(Signed) J. Mosc .....

(Date) 4-7-1990 .....



The University of Liverpool

FROM THE DEPARTMENT OF GENERAL PRACTICE

NEW MEDICAL SCHOOL  
ASHTON STREET P.O. BOX 147 LIVERPOOL L69 3BX

TEL: 061 - 709 - 6022 EXT.  
TELEX NO: 627096

COMMUNICATION IN PRACTICE: CONSENT FORMS

Name of patient:.....

Address:.....

.....

Form A (Initial interview).

"I am willing for this interview to be video-taped, and understand that it will be used only for training doctors or other health professionals."

Signed: ..... Date: .../.../...

Form B (Consultation with General Practitioner).

"I agree to this consultation being recorded on videotape, for the above purpose only."

Signed: ..... Date: .../.../...

Form C (After consultation)

"I agree to the videotape of this consultation being used for medical education. I understand that it will only be seen by doctors or other health professionals."

Signed: ..... Date: .../.../...

## BIBLIOGRAPHY

Albrow M 1970 *"Bureaucracy"*. London: Macmillan.

Anderson WT 1989 "Dentistry as an activity system: sequential properties of the dentist-patient encounter" in DT Helm et al (Eds.) *"The interactional order: New directions in the study of social order"*, New York: Irvington

Argyle M, Cook M 1976 *"Gaze and mutual gaze"*. Cambridge: Cambridge University Press

Armstrong D 1985 "Space and time in British general practice". *Social Science and Medicine* 20: 659-666

Atkinson P 1985 "Talk and identity: some convergences in micro- sociology". in H Helle and S Eisenstadt (Eds.) *"Microsociological theory"*, London: Sage, 117-132

Atkinson P and Heritage JC (Eds.) 1984 *"Structures of social action: studies in conversation analysis"*. Cambridge: CUP.

Bales RF 1950 *"Interaction process analysis"*. Massachusetts: Addison-Wesley.

Balint E and Norell JS (Eds.) 1973 *"Six Minutes for the Patient"*. London: Tavistock

Balint M 1964 *"The Doctor, his Patient, and the Illness"*. London: Pitman.

Boden D and Zimmerman D (Eds) 1991 *"Talk and social structure"*, Cambridge, Polity

Brown GW, Harris TO 1978 *"The social origins of depression"*. London: Tavistock

Browne K, Freeling P 1976 *"The Doctor-Patient Relationship"*. 2nd Ed. London & Edinburgh: Churchill Livingstone.

Bryman A 1988 *"Quantity and quality in social research"*. London: Unwin Hyman.

Buber M 1970 (Trans. W Kaufmann) *"I and Thou"*, T & T Clark, Edinburgh

Burrell G, Morgan G, 1979 *"Sociological Paradigms and Organizational Analysis"*.  
London, Heinemann

Butler N, Champion PD and Cox AD 1992 "Exploration of Doctor and Patient Agendas  
in general Practice consultations". *Social Science and Medicine*; 35:1145-1155

Butler JR and Calnan MW 1987 "List sizes and use of time in general practice". *Br Med  
J* 295: 1383-1386

Button G and Lee JRE (Eds.) 1987 *"Talk and Social Organisation"*. Clevedon,  
Multilingual Matters.

Byrne P and Long BL 1976 *"Doctors talking to patients"* London: HMSO.

Champion PD 1987 "Communication: learning from our patients". *The Practitioner*  
231:1056-1062

Champion PD (Ed.) 1988 *"Problems in doctor-patient encounters"*. (Video-tape series).  
London, Royal Society of Medicine.

Champion PD 1990 "Interaction analysis as a teaching tool." *Postgraduate Education for  
General Practice* 1:77-81

Champion PD, Samson SR, and Biscoe TJ 1968 "Effect of sinus nerve stimulation on  
activity of phrenic motoneurons". *Nature* 218:680-681

Cassidy M 1938 "Doctor and Patient". *Lancet* i:175-179 (cited in Tuckett et al, 1985)

Cassidy M 1946 "Coronary Disease" (The Harveian Oration of 1946). *Lancet* :587

Cicourel AV 1973 "*Cognitive Sociology*". Harmondsworth, Penguin.

Clark JA, Mishler EG 1992 "Attending to patients' stories: reframing the clinical task". *Sociology of Health and Illness* 14:(3).

Coulter J 1990 "Elementary Properties of Argument Sequences". In G Psathas (Ed.) "*Studies in Ethnomethodology and Conversation Analysis*". Washington DC, International Institute for Ethnomethodology and Conversation Analysis and University Press of America, 181-203

Elias N (trans. S Mennell and G Morrissey) 1978 "What is Sociology?" London, Hutchinson.

Emerson J 1970 "Behaviour in private places: sustaining definitions of reality in gynaecological examinations." in HP Dreitzel (Ed.) "Recent Sociology", New York, Macmillan, 73-100.

Fisher S and Todd A (Eds) 1983 "*The Social Organization of Doctor-Patient Communication*", Washington DC, Center for applied Linguistics.

Filmer P 1972 "On Harold Garfinkel's Ethnomethodology", in: P Filmer et al (Eds.), "*New Directions in Sociological Theory*", London, Collier-Macmillan.

Frank AW 1985 "Out of ethnomethodology" in H Helle and S Eisenstadt (Eds.) "*Microsociological Theory*", London, Sage, 101-116.

Frankel R 1989 "Microanalysis and the Medical Encounter: an Exploratory Study" in DT Helm et al (Eds.) "*The Interactional Order*". New York: Irvington, 21-49

Frankel R 1990 "Talking in interviews: a dispreference for patient-initiated questions in physician-patient encounters". In G Psathas (Ed.) *"Interaction Competence"* (op cit.), 231-262

Garfinkel H. 1967 *"Studies in Ethnomethodology"*, Englewood Cliffs, NJ: Prentice-Hall. (New edn 1984, Cambridge, Polity Press).

Garfinkel H and Sacks H 1970 "On formal structures of practical actions", in J C McKinney and E A Tiryakian (Eds.) *"Theoretical Sociology"*, New York: Appleton-Century-Crofts, 337-366

Goodwin C. 1981 *"Conversation Organisation: Interaction between speaker and hearer."* London, Academic Press.

Goodwin C and Heritage J 1990 "Conversation analysis." *Annual Reviews of Anthropology* 19:283-307

Graham P 1990 "A different interpretation of "we". *Postgraduate Education for General Practice* 1:211 (letter)

Greatbach D, Dingwall R 1989 "Selective facilitation: some preliminary observations on a strategy used by divorce mediators". *Law Society Reviews* 23: 613-642

Greatbach D, Luff P, Heath C, Campion P 1993 "Interpersonal communication and human-computer interaction: an examination of the use of computers in medical consultations." *Interacting with Computers* 5: 193-216

Have P ten 1989 "The consultation as a genre" In Torode (ed) *"Text and talk as social practice"*, Dordrecht: Foris, 115-135

Have P ten 1991 "Talk and Institution: a reconsideration of the "asymmetry" of doctor-patient interaction" in D Boden and D Zimmerman (Eds) *"Talk and social structure"*, Cambridge, Polity, 138-163

Heath C. 1986 *"Body movement and speech in medical interaction."* Cambridge, Cambridge University Press.

Heather N, Champion PD, Neville R, MacCabe D. "Evaluation of a controlled drinking minimal intervention for problem drinkers in general practice (the DRAMS scheme). *Journal of the Royal College of General Practitioners* 1987 37: 358-363

Helm DT, Anderson WT, Meehan AJ, Rawls AW (Eds.) 1989 *"The interactional order: New directions in the study of social order"*, New York: Irvington

Helman CG 1990 *"Culture, health, and illness"* (2nd Ed), Oxford: Butterworth-Heinemann.

Henbest RJ, Stewart M (1990) "Patient-centredness in the consultation. II: does it really make a difference?". *Family Practice*, 7:28

Heritage JC 1984 *"Garfinkel and ethnomethodology"*. Cambridge, Polity.

Heritage JC. 1987 "Ethnomethodology" in A Giddens and J Turner (Eds.) *"Social Theory Today"*, Cambridge, Polity, 224-272.

Heritage JC 1988 "Explanations as accounts: a conversation analysis perspective". In C Antaki (Ed.) *"Analysing everyday explanation: a casebook of methods"*. New York: Sage, 127-144

Heritage JC 1991 "Intention, Meaning and Strategy: Observations on Constraints on Interaction Analysis". *Research on Language and Social Interaction*, 24:311-332

Heritage J, Atkinson JM 1984 "Introduction" in JM Atkinson and J Heritage (Eds.) *"Structures of Social Action"*, Cambridge: CUP.

Heritage J, Greatbach D 1991 "On the Institutional Character of Institutional Talk: The Case of News Interviews". In D Boden and DH Zimmerman (Eds.) *"Talk and Social Structure"*, Cambridge, Polity, 93-137

Heritage JC, Watson DR 1980 "Aspects of the properties of formulations in natural conversations: some instances analyzed" *Semiotica*, 30: 245-262

Horobin G, McIntosh J 1983 "Time, risk and routine in general practice". *Social Science and Medicine* 5:312-331

Howie JGR, Porter ADM, Forbes JF 1989 "Quality and the use of time in general practice: widening the discussion". *Br Med J*;298:1008-10

Huygen FJA 1978 *"Family Medicine: the Medical Life History of Families"*. Nijmegen; Dekker and van de Vegt.

Jefferson G 1972 "Side Sequences". In D Sudnow (Ed.) *"Studies in Social Interaction"*. New York: Free Press, 294-338

Jefferson G 1978 "Sequential Aspects of Storytelling in Conversation" in J Shenkein (Ed.) *"Studies in the organisation of conversational interaction"*. New York: Academic Press, 219-248

Jefferson G 1984 "Transcription conventions." in P Atkinson and JC Heritage(Eds.) 1984 *"The structure of social action: studies in conversation analysis"*. Cambridge: CUP.

Jefferson G 1985 "An exercise in the transcription and analysis of laughter" in T van Dijk (Ed.) *"Handbook of discourse analysis"* Volume 3, London, Academic Press.



Jefferson G, Lee JRE 1980 "The analysis of conversations in which "troubles" and "anxieties" are expressed". Final Report to the Social Science Research Council. Manchester: University of Manchester.

Jefferson G, Lee JRE 1981 "The rejection of advice: managing the problematic convergence of a "Troubles telling" and a "Service encounter"". *Journal of Pragmatics* 55: 399-422

Kendon A. 1982 "The organization of behaviour in face-to-face interaction: observations on the development of a methodology." in KR Scherer, P Ekman (Eds) *Handbook of Methods in Nonverbal Behaviour Research*. Cambridge, CUP, 440-505

Kleinman A, Eisenberg L, Good B 1978 "Culture, illness and care: clinical lessons from anthropologic and cross-cultural research". *Annals of Internal Medicine*, 88: 251-258

Korsch BM, Gozzi E, Francis V 1968 "Gaps in doctor-patient communication: I. Doctor-patient interaction and patient satisfaction". *Pediatrics* 42: 855-871

Lee JRE 1987 "Prologue: Talking organisation" in G Button and JRE Lee (Eds.) *Talk and Social Organisation*, Clevedon, Multilingual Matters.

Levenstein JH, McCracken E, McWhinney IR, Stewart M, Brown JB. 1986 "The patient-centered clinical method. A model for the doctor-patient interaction in family medicine". *Family Practice* 3:24-30

Livingston E 1987 *Making sense of ethnomethodology*, London, Routledge and Kegan Paul.

Lowe I 1969 "An algebraic theory of English pronominal reference." (Part 1) *Semiotica*, 1(4): 397-421 (cited in DR Watson (1987) p. 263)

Major RH 1945 *"Classic descriptions of disease"* (3rd Edition). Springfield, Ill.: Charles C Thomas.

Mehan H 1991 "The school's work of sorting students", in D Boden and DH Zimmerman (Eds.) *"Talk and social structure"*. Cambridge: Polity, pp. 71-90

Mishler EG 1984 *"The discourse of medicine: dialectics of medical interviews."* Norwood, NJ: Ablex.

Morrell DC, Evans ME, Morris RW and Roland MO 1988 The "five minute" consultation: effect of time constraint on clinical content and patient satisfaction. *Br Med J*; 292: 870-873

Myerscough PR 1989 *"Talking with patients"*, Oxford: Oxford University Press.

Nijhof G 1989 "On naturalization in health care" in B Torode (Ed.) *"Text and talk as social practice"*. Dordrecht: Foris, 136-153.

Norell JS 1973 "Introduction" in E Balint and JS Norell (Eds.) *"Six Minutes for the Patient"*. London: Tavistock.

Parkinson J 1945 "Rheumatic fever and heart disease" (The Harveian Oration of 1945). *Lancet*: 1945, ii, 657.

Parsons T. 1968 *"The Structure of Social Action"* (Vols I & II). New York; Free Press.

Pendleton D, Tate P, Havelock and Schofield T 1984 *"The Consultation: an approach to learning and teaching"*. Oxford: OUP.

Pike KL 1966 "Modelling pronominal reference". *Language* 41:192-215 (Cited in DR Watson (1987) p 263)

Pomeranz A 1978 "Compliment responses" in Schenkein (Ed.) *"Studies in the organisation of conversational interaction"*. New York: Academic Press

Potter J and Wetherell M 1987 *"Discourse and social psychology"*, London: Sage.

Preston-Whyte ME 1992 "Doctor-patient communication". In R Frazer (Ed.) *"Clinical method: a general practice approach"*, (2nd Edn) Oxford: Butterworth-Heinemann, 93-112

Pringle M, Stewart-Evans C. 1990 "Does awareness of being video recorded affect doctors' consultation behaviour?". *Br J Gen Pract*; 40:455-458

Psathas G (Ed.) 1973 *"Phenomenological Sociology"*. New York, John Wiley

Psathas G (Ed) 1979 *"Everyday Language: Studies in Ethnomethodology"*. NY, Irvington.

Psathas G (Ed.) 1983 *"Interactional Competence"*, Washington DC, University Press of America.

Psathas G (Ed) 1990 *"Studies in Ethnomethodology and Conversation Analysis"*. Washington DC, International Institute for Ethnomethodology and Conversation Analysis and University Press of America.

Psathas G 1990 "Introduction: Methodological issues and recent developments in the study of naturally-occurring interaction" in G Psathas (Ed.) op. cit.

Psathas G 1990 "The Organization of talk, gaze and activity in a medical interview" in G Psathas (Ed.) op. cit., 205-230

Rawls AW 1989 "An Ethnomethodological perspective on social theory" in DW Helm et al (Eds.) *"The interactional order: New directions in the study of social order"*, New York: Irvington, 4-20

- Ridsdale L, Carruthers M, Morris R and Ridsdale J 1989 "Study of the effect of time availability on the consultation". *J Roy Coll Gen Pract* 39, 488-491
- Roland MO, Bartholomew J, Courtenay MJF, Morris RW, Morrell DC. 1986. "The "five minute" consultation: effect of time constraint on verbal communication". *Br Med J* 292:874-876
- Sacks H 1972 "An initial investigation of the usability of conversational data for doing sociology" in D Sudnow (Ed.) *"Studies in Social Interaction"*. New York: Free Press, 31-74
- Sacks H 1975 "Everyone has to lie" in M Sanches and B Blount (Eds) *Sociocultural Dimensions of Language Use*. New York: Academic Press, 57-80
- Sacks H 1984 "Notes on methodology." In: JM Atkinson and J Heritage (Eds.) *"Structures of social action: studies in conversation analysis"*, Cambridge, Cambridge University Press.
- Sacks H 1985 "The inference-making machine: notes on observability", in T van Dijk (Ed.) *"Handbook of discourse analysis"* Volume 3, London, Academic Press, 13-23
- Sacks H 1987 "On the preferences for agreement and contiguity in sequences in conversation". In G Button and JRE Lee (Eds.) *op. cit.*, 54-69
- Sacks H 1992 *"Lectures on Conversation"* (Ed. G Jefferson) Oxford: Blackwell (Vols 1 and 2)
- Sacks H, Schegloff EA, Jefferson G 1974 "A simplest systematics for the organization of turn-taking for conversation" *Language* 50 (4):696-735
- Sacks H, Schegloff EA, Jefferson G 1978 "A simplest Systematics for the Organization of Turn Taking for Conversation" in Schenkein J (Ed.) *"Studies in the Organization of Conversational Interaction"*, London: Academic Press

Schegloff EA 1981 "Discourse as an interactional achievement: some uses of "uh huh" and other things that come between sentences" in B Tannen (Ed.) *Analyzing Discourse: Text and Talk*. Washington DC: Georgetown University Press.

Schegloff EA 1992 "Introduction". In Sacks H. *Lectures on Conversation* (Ed. G. Jefferson), Oxford: Blackwell.

Schegloff EA and Sacks H 1973 "Opening up closings" *Semiotica* 8:289-327, (reprinted in R Turner (Ed) 1974 *Ethnomethodology*, Harmondsworth: Penguin, 233-264)

Schenkein J 1978 "Sketch of an Analytic Mentality" in J Schenkein (Ed.) *Studies in the organisation of conversational interaction*. New York: Academic Press, 1-6

Schenkein J 1978 "Identity Negotiation in Conversation" in J Schenkein (Ed.) *Studies in the organisation of conversational interaction*. New York: Academic Press, 57-78

Schutz A 1967 *Collected papers. I, The problem of Social Reality* (Ed. M Natanson)(2nd edn.) The Hague: Martinus Nijhoff

Schutz A 1964 *Collected papers. II, Studies in Social Theory*. (Ed. A Brodersen), The Hague: Martinus Nijhoff

Sharrock W, Anderson R 1986 *The Ethnomethodologists*. Chichester, Ellis Horwood.

Sharrock W, Anderson R 1987 "Work flow in a paediatric clinic". In G Button and JRE Lee (Eds.) *op. cit.*, 244-260

Sharrock W, Anderson R 1987 "Epilogue: the definition of alternatives". In G Button and JRE Lee (Eds.) *op. cit.*, 290-321

Schon DA 1987 *Educating the reflective practitioner*. San Francisco: Jossey Bass.

Silverman D 1987 *"Communication and medical practice"*. London: Sage.

Silverman D 1993 *"Interpreting qualitative data; methods for analysing talk, text, and interaction."* London: Sage.

Spiegelberg H 1973 "On the right to say 'we': a linguistic and phenomenological analysis", in G Psathas (Ed.), *"Phenomenological Sociology"*. New York: John Wiley, 129-156

Spence J 1960 *"The purpose and practice of medicine"*. London: Oxford University Press.

Stewart M, Roter D (Eds.) *"Communicating with medical patients"*. London: Sage

Strong PM 1979 *"The ceremonial order of the clinic. Parents, doctors, and medical bureaucracies"*. London, Routledge & Kegan Paul.

Sudnow D (Ed.) 1973 *"Studies in Social Interaction"*. New York: Free Press.

Torode B.(Ed.) 1989 *"Text and talk as social practice."* Dordrecht: Foris.

Treichler PA Frankel RM, Kramarae C, Zoppi K, and Beckman HB 1984 "Problems and problems: Power relations in a medical encounter" in Kramarae C, Schultz M and O'Barr WM (Eds) *"Language and Power"*, New York, Sage, 62-88

Tuckett D, Boulton M, Olson C, Williams A. 1985 *"Meetings between experts"*. London, Tavistock

Watson DR (1987) "Interdisciplinary considerations in the analysis of pro-terms", in G Button and JR Lee (Eds.) *"Talk and social organisation"*. Clevedon: Multilingual Matters, 260-289

Watson DR and Sharrock WW 1991 *"Something on accounts"*. The D.A.R.G Newsletter 7:2:3-12

West C 1984 *"Routine complications: troubles talk between doctors and patients"*. Bloomington, Indiana University Press.

Wilkin D and Metcalfe D 1984 "List sizes and patient contact in general medical practice". *Br Med J* 289: 1501-1505

Wilson TP 1987 "Sociology and the mathematical model", in A Giddens and J Turner (Eds) *"Social Theory Today"*. Cambridge, Polity Press, 383-404

Wilson TP 1991 "Social Structure and Interaction" in Boden D and Zimmerman DH (eds) *"Talk and Social Structure"*. Cambridge, Polity.

Zimmerman D 1988 "On Conversation: The Conversation Analytic Perspective". *Communication Yearbook* 11: 406-432

Zimmerman DH, Boden D 1991. "Structure-in-Action: and Introduction." in D Boden and DH Zimmerman (Eds.) *"Talk and social structure"*. Cambridge: Polity, 3-21

