

THE INTERACTIONAL CONSTRUCTION OF ASYMMETRY: The Medical Agenda as a Resource for Delaying Response to Patient Questions

Felicia Roberts
Purdue University

This study is based on transcriptions of twenty-one audiotaped encounters between patients with breast cancer and their oncologists. Using a conversation analytic approach, findings reveal how oncologists invoke a clinical agenda to postpone response to certain patient questions or to mark them retroactively as “out of order.” These deferral actions take the shape of “pre-insert expansions” in which the physician *mentions* an activity to be performed (e.g. the physical exam) prior to actually initiating the activity. Once this clinical exigency has been invoked, patients do not pursue their questions further. They thereby relinquish their request for information and “accept” that answers will be forthcoming. Thus, the oncologist uses the clinical agenda as a resource for managing the direction of the talk, and patients orient collaboratively to that agenda.

In the context of a discussion of asymmetry in clinical discourse, Douglas Maynard (1991a, p. 449) proposes that asymmetry derives “partly from participants’ indigenous resolution of interactive problems that transcend doctor-patient dialogue.” In this article, I will explore how a certain interactive problem, namely, avoiding answering a question, is indeed relevant for fashioning a more nuanced understanding of asymmetry. The purpose is to see how oncologists and patients assemble themselves, through talk, into an observably asymmetrical relationship. As will be shown, physicians have a resource, an agenda of medical activities, that they can invoke to delay response to patient questions. For their part, patients cooperate in these delays by not pursuing an inquiry once it has been marked as “out of order.”

Stepping back for a moment from the professional setting, we know from experience in everyday conversation that an interactant can respond to a question or topic proffer by simply saying that he or she “doesn’t want to talk about it,” formulating the request or topic as unwelcome in some way. The following excerpt from a videotape of a family gathering exemplifies this. Here, John asks Mary about a particular event; she first responds by saying she doesn’t want to talk about it but then provides an answer.

Direct all correspondence to Felicia Roberts, Department of Communication, Purdue University, 1366 LAEB, Room 2114, West Lafayette, IN 47907-1366; e-mail: froberts@purdue.edu

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Family Gathering (simplified transcript)

1. John: So how did it go?
2. Mary: ((leans in to her plate to get food on fork))
3. Oh no. ((left hand goes up in a "stop" motion))
4. I don't wanna talk about that now heh. Went very well. Went very well.

Here, Mary clearly displays some initial unwillingness to discuss the topic raised by John. First, she delays offering *any* response while she gets some food on her fork; then, her "Oh no" makes it verbally clear that she is reluctant to take up the topic (Heritage 1998) while her nonverbal "stop" motion (the raised hand) punctuates the turn. She explicitly (and good naturedly) says that she doesn't want to talk about "that" but does, in fact, finally answer the question (at line 4).

Although the example from the family gathering may not be immediately relatable to our discussion of institutional asymmetry, it is important to keep the "everyday" example in mind as we explore how oncologists move to "stop" patient inquiries. In ordinary conversation, if one wants to avoid a particular topic, one can certainly do so; however, this is a potentially delicate matter. It is probably rather difficult to put off inquiries for very long without recourse to questions about the question, or displays of discomfort, drama, joviality, or the like. Professionals, too, must find ways to avoid discussing what they are not ready to, yet they may not as readily draw on the same resources available in everyday encounters. This article investigates the deployment of a particular resource that *is* available to them, the clinical agenda, and explores how oncologists and patients collaboratively construct a course of action and organize, through their local practices, who will be "in charge" and what the encounter may be about, i.e., what is relevant for discussion and at which particular time.

This approach to detailing how asymmetry is enacted as a situated accomplishment is rooted in an ethnomethodological perspective: analytic attention will highlight participant actions, revealing how they methodically construct their social world in real time (Garfinkel 1967; Garfinkel and Sacks 1970). Specifically, I employ the "analytic technology" (Heritage 1988, p. 129) of conversation analysis to illuminate the procedures of "talk-in-interaction" which produce the social organization under consideration (Schegloff 1987b). Contrary to an approach that would have recourse to more abstract conceptual explanations (such as "power") to explain locally produced social order, this article aims to provide a detailed examination of actual interactions and thus explore how an asymmetrical relationship is collaboratively achieved—how members organize such a thing.

This perspective is quite different from research approaches to medical sociology that have considered asymmetry to be an *effect* of institutional structures and rules (see reviews in Maynard 1991a; ten Have 1991). From that vantage point, the doctor's individual authority derives from his or her access to the specialized knowledge and institutional resources that constitute medical help (Freidson 1970; Parsons 1951). Or, physicians are seen as participating in and reproducing a larger sociopolitical structure that exploits and subordinates patients to the ideology of science (e.g., Navarro 1976; Waitzkin 1979). More communicatively oriented approaches describe conflicts between the scientific orientation of physicians and the personal/community understandings of patients (Kleinman 1980; Mishler 1984). While it is true that physicians have access to the substance and practice of medical knowledge, these more abstract explanations fall short of understanding the situated machinery of interaction that produces an observably asymmetrical relationship.

Analysts must be careful not to view talk as a “by-product” (West 1984, p. 34) of larger forces at work, ignoring participant agency and reducing interaction to a mere acting out.

Recent explorations of doctor-patient interaction have shown that asymmetry, organized as differential attention to and displays of knowledge, is created and sustained by members as endogenous features of interaction (Gill 1998; Heath 1992; Maynard 1991a; 1991b; ten Have 1991). For example, Virginia Gill (1998) has demonstrated that patients’ causal explanations of their illness can be constructed in such a way that physicians accountably avoid assessing the explanation (thus avoiding assessment of patients’ theoretical knowledge) by focusing instead on the facts or evidence mentioned (deferring to patients’ empirical knowledge of their symptoms). In other words, institutional asymmetry appears to be a profoundly “social process” (Gill 1998, p. 357) in which participants methodically organize themselves—their verbal and nonverbal contributions—in such a way as to collaboratively construct differential knowledge and behaviors.

To build on this emergent understanding of asymmetry in medical settings, I explicitly take up a challenge presented by Emmanuel Schegloff (1991, p. 66): to “convert insistent intuition into empirically detailed analysis,” that is, to take the insistent intuition (or social “fact”) that doctors are powerful and see how that is a locally managed accomplishment. The question thus confronting us is, how do physicians and patients create and sustain asymmetry in the details of their talk? In this way, we may better understand how context is an achievement of participants and not simply a set of external forces shaping interaction.

Here I present a brief overview of findings in the context of previous conversation analytic work on questions in medical settings; the data and analytic approach are then discussed, followed by a close analysis of transcribed excerpts. Finally, I summarize the findings and offer concluding remarks regarding the value of this approach to “establishing a revitalized sociology of work and occupations” (Silverman 1998, p. 167).

OVERVIEW OF FINDINGS

Conversation analytic studies of doctor-patient interaction in general internal medicine consultations reveal that patient questions² often fail to elicit answers from the doctor (Frankel 1989; West 1983; West and Frankel 1991). What the present data show is that it is not patient questions per se that are dispreferred but rather the formulation and positioning of the question relative to the larger purpose of the visit. This argument for attending to sequential relevance (or local positioning) was first presented by Paul ten Have (1991) for general medical clinics in the Netherlands.

In the current data, oncologist-patient interactions in the United States, that observation holds true in some interesting ways. I will show that questions formulated prior to the physical exam (i.e., during the medical history interview), which seek reassurance about disease causation are answered. Those queries which seek information relative to treatment, are deferred by the oncologist. These deferrals take the shape of what I call a “pre-insert expansion” in which the physician invokes a set of clinical activities to be performed (e.g., the physical exam) before actually performing them. In other words, this is a kind of verbal pointing before engaging in an activity. As such, the pre-insert is a resource for delaying response to a question while still promising an answer to be forthcoming.³

For their part, patients do not pursue immediate answers to their questions, thereby relinquishing their request for information and “accepting” that answers will be forthcoming. Together, doctor and patient thus achieve an orientation to a larger activity, “what the

visit is about." Notably, however, once the physical exam has intervened, rarely is there an explicit rementioning by the physician of a *particular* question. Thus, just because the physician says that a topic will be retrieved later does not mean that it will be returned to in any explicit fashion.

DATA AND ANALYTIC APPROACH

Data

The data for the current analysis comes from audiotapes of conversations between breast cancer patients and medical oncologists. These recordings were collected as part of a larger study concerning the correlates of breast cancer adjuvant treatment decisions; all recordings were made at a teaching hospital associated with a comprehensive cancer center. A detailed description of data collection procedures for the parent study appears in Laura Siminoff (1987) and in a series of studies by Siminoff and colleagues (Siminoff and Fetting, 1989; 1991; Siminoff, Fetting, and Abeloff 1989). Briefly, patients in the larger study were adult women who had undergone surgery for breast cancer; the audiotapes were made of the meeting between each study patient and her oncologist at which they discuss options for adjuvant therapy (e.g., chemotherapy, hormonal therapy, and radiation.)

For the current analysis, twenty-one audiotapes were selected based on the clarity and completeness of the recording, where "complete" constituted capturing the clinic visit from beginning to end. Within this group, there are eight physicians (one is female), and the patients range in age from 22–73. White and African American women are represented in both older and younger age brackets.

Also included in the present discussion are excerpts taken from an individual's personal videotape of a haircut appointment at a cosmetology school and a videotape of a family gathering. However, when referring to "data" for this study, the reader should understand that term as referring only to the recordings and transcripts of the medical encounters.

Methodology

The central analytic work for this study began with the detailed transcription of the twenty-one audiotaped clinic visits, which I transcribed, enabling me to follow each interaction in detail from beginning to end. Transcription conventions follow on Gail Jefferson (1974), adapting somewhat to accommodate my keyboard (the conventions used are in Appendix 1).

Once the tapes were transcribed, I started line-by-line analysis of each consultation. The interaction was approached in an "unmotivated" way (Sacks 1984), assuming as little as possible about the participants and what they were doing. This was particularly easy as the audiotapes had been collected without my participation. Approaching the data in this open way led to insights that were then carried to the rest of the encounters. Recurrent patterns were noted as well as problematic or disrupted patterns. In this way, the analysis took shape "on the back of the single case" (Schegloff 1993). The phenomenon of interest in the current analysis, the manner in which the clinical agenda is invoked to delay patient questions, was noted in one interaction and examined in detail. This single case demonstrated the "machinery of production" (Psathas 1995, p. 50) in that particular instance; the recurrence of the phenomenon in other cases did not prove the adequacy of the single case

analysis, but it was a means for noting and exploring variation (see also Benson and Hughes 1991; Psathas 1995, pp. 50–53 on “method of instances”).

Analytic Approach

I approach this conversational data by privileging the finely detailed, empirically verifiable aspects of talk-in-interaction. This is the theoretical and methodological foundation of conversation analysis (CA), which is grounded in ethnomethodology (Garfinkel 1967). Indeed, Harold Garfinkel (1991, p. 14) enfold the contributions of CA into those of ethnomethodology in an article summarizing findings from these closely allied forms of science (Garfinkel 1991, p. 14). As John Heritage (1984, p. 235) describes it, CA is a form of ethnomethodological work initiated by Harvey Sacks to “keep a grip” on the primary data of the social world. Within the conversation analytic framework, sequential organization is a central concern (Sacks, Schegloff, and Jefferson 1974; Schegloff and Sacks 1973), and because context is understood as locally and methodically constructed (Garfinkel 1967), there is a constraint on analysis that calls for strict attention to adjacent utterances; interaction is to be understood *as it unfolds for the participants*.

Briefly, the ethnomethodological/conversation analytic approach treats context not as an external phenomenon shaping discourse but as something shaped through emergent participant talk and action (see also Pomerantz and Fehr 1997; Schegloff 1992; 1997). Or, as Paul Drew and John Heritage (1992, p. 17) describe it, conversation analysis provides an “empirical analysis of the nature of context.” By attending to the sequential details of verbal and nonverbal interaction, it becomes apparent how participants create a context through their local orientation to moments in the ongoing talk (Pomerantz and Fehr 1997, pp. 66–70).

ANALYSIS

Excerpts are presented here from the transcribed encounters in which patient questions are either specifically answered or specifically delayed. Although these are glossed as categorically different entities (answerable vs. unanswerable) for the ease of presentation, the issue is not whether the questions themselves are answerable or not, rather the answerableness is revealed in the physician’s orientation to the question as answerable and in the way that patients formulate their questions such that varying levels of “pressure” (Gill 1998) are on the physician to provide an answer. Questions treated by the physician as “answerable” are those that specifically request his opinion and concomitantly display patient uncertainty. Questions treated as “unanswerable” are those formulated as direct yes/no questions; in these, the patient is asking not for an opinion but for specific information.

Answerable versus unanswerable questions also seem to be “about” different things: the former are patients’ searches for explanations or reassurances about what may (or may not) have caused their cancer. Unanswerables (or delayables) are patient requests for specific information about treatment: side effects, aspects of prognosis, quality of life, and so on. One might say that the answerable questions are about something that is backward-looking (why the patient got cancer) whereas the delayables are forward-looking (what may be expected next.) By delaying the forward-looking questions, the oncologists display an orientation to the “official business of the encounter” (Heritage and Sorjonen

1994, p. 6) by moving to stall the topic of treatment until all preliminary activities are accomplished; treatment topics are thus handled as a kind of culminating activity. That the patient cooperates in the delay by not pursuing the currently “unwelcome” topic is evidence that together they achieve the maintenance of this larger activity, orienting to a “goal-coherent course of action” (Heritage and Sorjonen 1994, p. 4). The fact that there is a larger activity in progress which can be “returned to” (Heritage and Sorjonen 1994, p. 4) is thus an observable feature of the interaction, created and sustained by the participants.

Questions Treated as Answerable

In the following excerpts, patients’ concerns about their disease are handled as they arise. In excerpt 1 the oncologist has been engaged in gathering the story of the patient’s discovery of her breast lump and subsequent surgery. The oncologist follows this by asking her how she’s been feeling, which turns to the patient discussing how she missed a previous appointment for two reasons: she wasn’t feeling well and she hadn’t had her hair “fixed.” At that point the doctor tells her that her hair looks fine. Immediately following that remark, the patient asks for the oncologist’s opinion about the relationship between hair coloring and cancer. Although he provides an initial response to her query, she pursues the topic until she gets reassurance that she can continue to color her hair.

Excerpt 1

- 138 PT 44 Did you-do you think that putting color on your
 139 hair might have something to do with the cancer?
 140 DR 5 Nope?
 141 PT 44 Because see I don’t smoke, I don’t drink, heh .hh
 142 I don’t know what does [it.
 143 DR 5 [Well we don’t-
 144 PT 44 [()]
 145 DR 5 [We don’t know what] causes breast cancer. We
 146 (.) we don’t think smokin or drinkin or hair
 147 coloring has anything to do with it.
 148 PT 44 Oh ya don’t? =
 149 DR 5 = [No.
 150 PT 44 [uh huh
 151 DR 5 But we don’t know what causes breast [cancer.
 152 PT 44 [Well I
 153 wondered, cause I had read (.) ya know they said
 154 (1.0) uh:: colorin your hair is bad for ya,= You read
 155 so many things you get so confused. You don’t know
 156 what to do.
 157 DR 5 No:: you can keep colorin your hair.
 158 PT 44 Oh, okay, fine.
 159 DR 5 Okay? Alright. Uh:: any other pain besides that. . .

Of note is that the patient is not simply formulating a request for information: the “question” she asks (line 138) is actually proposing a possible causal link between hair coloring and cancer. She phrases this as a request for the doctor’s opinion (“do you think”) and as a speculative causal explanation (“might have something to do with”) thereby marking her uncertainty. The physician’s unequivocal answer (“Nope?” line 140) that he

doesn't think hair coloring has anything to do with her cancer does not seem to close the subject. The patient works to keep the topic open by providing a post-positioned account for her initial query (line 141, she ostensibly has no other bad habits—i.e., smoking or drinking). The oncologist's replies are consistently reassuring that none of the elements mentioned by the patient are likely causal factors in her cancer. She continues her pursuit by again accounting for her "wondering" (lines 153–156) in that she had read that hair coloring is bad for you. Once he tells her that she can keep coloring her hair, she no longer pursues the subject, and they cooperatively return to medical history taking.

In this interaction the oncologist responds to each of the patient's queries with some kind of an answer: "No" responses at lines 140 and 149 and in lines 145–147 an explanation that, while no one knows what causes breast cancer, the agents named by the patient are not linked to the disease. The oncologist not only provides answers to her explicit questions, but also elaborates on what he may sense as her implicit "why" question—what causes cancer in general and her cancer in particular. There is no delaying of the patient's concerns to some future point in the consultation nor is there any sidestepping of the issue. The reassurance that the patient can continue to color her hair is apparently adequate for her, and they continue with the medical history taking.

In the next example (excerpt 2), the patient has come to the oncologist for a second opinion. They have been talking about the treatment recommendation as it stands from another physician, and this oncologist concurs with that first opinion. The doctor moves to get some visual aids to further elaborate on the drugs that have been recommended and asks the patient for any further questions before he does that.⁴ When the patient asks if having her first child at age thirty-six might have "had any impact [on the cancer]," the oncologist provides a response.

Excerpt 2

- 446 DR 9 Uhhm (1.25) Do you have any other questions before I
 447 go get ss- the cards that talk about the drugs?
 448 PT 92 Uh, yeah.
 449 DR 9 Okay?
 450 PT 92 Heh heh heh .hhh I wanted to get (.) your opinion as to whether or not (.) .hhh
 451 uhm the fact that I had ya know my first child at thirty-six. (.) had any impact on
 452 this,
 453 DR 9 Well [statistically,
 454 PT 92 [cancer.
 455 DR 9 I can't answer the question for you as an individual. I can answer it (.) in terms
 456 of population. ((explanation continues))

Here, the patient presents her question not only as potentially "silly" (note the laughter tokens that preface the question in line 450) but also quite clearly as a request for the physician's opinion. The talk in lines 450–452 is mitigated and hesitant, displaying uncertainty about the causal explanation she is exploring. Although the oncologist's contribution at lines 455–458 doesn't "answer" the patient's question about her *particular* case, it appears to provide an adequate response in that the patient does not pursue the matter further after the oncologist has finished his explanation (data not shown).

In both of these cases (excerpts 1 and 2) where patients seem to be requesting reassurance or understanding about what caused their cancer, the oncologists are disposed to provide answers. The way that patients ask for the doctor's opinion is a relatively "high pressure"

(Gill 1998) formulation. The form “do you think” “pointedly calls for the doctor’s evaluation” (Gill 1998, p. 346) and sets up the “conditional relevance” (Schegloff 1972, p. 76) of an answer. That is, after such a formulation, an answer would be “notably absent” (Schegloff 1972, p. 77) if it were not offered or if some alternative (e.g., an insert expansion) were not initiated.

The formulation by patient 92 in excerpt 2 (“I wanted to get your opinion”) is perhaps less weighty, but the empirical matter raised in the implicit causal explanation (having a first child at age thirty-six) doesn’t particularly lend itself to further focused inquiry. Thus, both of these formulations of causal explanations (and their implicit appeal for reassurance) are responded to by the oncologist and tend to support the analysis proposed by Gill (1998).

In contrast to these answerable questions, some topics raised (in the guise of questions or statements) are not answered by the oncologist in the canonical answer slot, even though the formulations are perhaps even more direct than those just examined. In these situations, the physician delays a response by invoking the medical agenda, a move that puts off answering to a later time. We now turn to the shape of the clinical agenda and the way in which it is used as a resource to delay certain patient questions.

The Clinical Agenda

The six phases of medical visits originally described by Patrick Byrne and Barrie Long (1976), an analysis further refined by Christian Heath (1992), characterize these oncology encounters as well. Although the visits are not diagnostic—the patients have already undergone surgery for cancer—the oncologists engage, nevertheless, in the same sequence of activities characteristic of general medical visits. A few adjustments within particular phases are apparent, though need not be detailed here (for a full discussion, see Roberts 1999).

The presentation of the medical agenda usually unfolds unproblematically; it is presented as a simple projection of future activity by the oncologist and is agreed to by the patient. The following two excerpts are examples of how the oncologist proposes to move through an agenda of activities in a particular order. In excerpt 3, the oncologist first mentions that he’d like to hear the patient’s concerns (A Arrow). Then in excerpts 3 and 4, the oncologists express a preference for first doing a physical exam (B Arrows) then speaking to the concerns raised by the patient (C Arrows).

Excerpt 3

- 102 PT 27 . . . I but I just wanted someone else’s
 103 opinion.
 104 DR 4 Okay. Let’s do this then, um let me just catch up
 105 A→ quickly with ya about how ya been feelin. I’d
 106 B→ like to examine ya briefly. and then we’ll
 107 C→ leave plenty a time to talk about these(.)
 108 *things*. I can give ya straight forward answers
 109 *today for these questions.*
 110 PT 27 Well that’s what I want.

Excerpt 4

- 114 DR 2 Have ya (.) ever had any allergies or any bad
 115 reactions to *any medications that you-
 116 PT 2 [no
 117 DR 2 [*know of. Okay.*

- 118 (2.0)
 119 DR 2 Well what I thought we'd do is uh
 120 PT 2 ((sniff))
 121 DR 2 B→ I'd examine you and the::n we'd talk a bit
 122 C→ about (.) what it means to have a couple of
 123 lymph nodes positive. in breast cancer.
 124 What we know about that. (.) And what it
 125 means (.) in t- in terms of lo::ng term
 126 outlook (.) an::d what kind of treatments(.)
 127 are given in order to try to improve (the)
 128 outlook. *Keh?* (.) I'd like to do that after I
 129 take a look at you *n examine ya*.
 130 PT 2 mm
 131 DR 2 Kay? so why don't I have you step in there
 132 put a gown on . . .

These early and explicit statements of the two oncologists' plans are common across the data and serve as evidence of their orientation to perform certain tasks within the time-span of the current visit; the patient is invited to cooperate in that order of events. The activity is presented as something they will embark upon together. In excerpt 3, line 104, the oncologist formulates it as "let's do this then," and in excerpt 4, line 119, the proposal is shaped with "What I thought we'd do." As noted by Marjorie Goodwin (1990, p. 317) in a discussion of children's organization of play activity, "let's" and "we" can introduce imperatives in such a way that cooperation is highlighted. Thus, if we think of the mitigated directives as first pair parts of an adjacency pair, then the second pair part is the patients availing themselves of examination gowns and undergoing the physical exam. The clinical activities are thus cooperatively organized; patients agree to the physical exam, as they do to the other components of the visit, as constituent features of these encounters.

In an encounter of a very different sort (in terms of the activities to be accomplished), information gathering prior to advice giving is also made relevant. In the following exchange, a woman (Barb) is about to get her hair cut. The haircutter (Ann) moves to delay Barb's contributions by indicating that she has a preference for a particular sequence of events, namely, to assess the state of Barb's hair first. By orienting to the client's contributions as premature, the haircutter presents her agenda as superseding the client's. (In the transcript, nonverbal actions are presented in a simplified form in italics in double parentheses.)

Haircut Excerpt

- 1 Ann Okay. Then we'll let you be this part. ((*B takes chair and A is to the side*))
 2 Barb Thanks.
 3 Ann *Okay uh::hm* ((*moving toward back of B, hands out toward B's head*))
 4 Barb So::: .hhh
 5 (1.5) ((*B is moving her hands to her ears to remove her earrings*))
 6 ((*A is moving hands behind B's head to undo B's hairclips*))
 7 Barb [Uhm
 8 Ann [First let's, ((*A is working hands behind head, undoing hair clips*))
 9 Barb Okay. ((*B gets earrings out and move her hands to lap*))
 10 (1.25) ((*A gets hair clips undone. B's hair falls out to her*
 11 *shoulders*))
 12 Barb The thing is [that- ((*A spreading out B's hair with her hands*))

- 13 Ann [have a loo::k and see what it looks like, fi::rst
 ((A unclumping B's
 hair))
 14
 15 Barb Okay. ((looks to her lap and smiles))
 16 (2.0) ((A leans to front of B and puts clips on counter still holding
 17 B's hair and loosening it))
 18 Ann No::w, I'm assuming you like to do be able to do something fairly quick and
 19 easy and you don't wanna spend a lotta ti:me, right?

The focus here is on the way in which Ann formulates her turn as continuing despite Barb's contribution at line 12. Barb's receipt ("okay" at line 9) of Ann's projection of a "first" activity (at line 8) seems incontrovertible at line 10 where, during the pause in the talk, Ann is undoing Barb's hair. However, at line 12, with the turn "up for grabs," Barb begins to formulate an utterance that may be on its way to describing a particular problem or situation. Regardless of the projected contribution from Barb, Ann continues her turn as though uninterrupted, working to "sequentially delete" (Schegloff 1987, p. 110) Barb's initiated utterance.⁵ Not only does Ann continue with her utterance, she also repeats the word "first" at line 13, which is the word that had launched her turn in line 8, effectively restarting her turn beginning (Local 1992). To gloss this as "insistence" that Ann wants to get something done prior to Barb taking the floor does not seem far off. Ann clearly moves to advance her agenda of (ostensibly) assessing the state of Barb's hair. This display of agenda setting may be not only functional in that Ann actually gets an uninterrupted moment to examine Barb's hair, but it also establishes who is "in charge" of the interchange. Thus, the agenda of activities serves not just a clinical function; it also serves, when invoked by a participant, to calibrate a turn-taking sequence so that one party displays control over the unfolding succession of turns. In the oncology visits, as in this hair-cutting exchange, the agenda can be invoked as a resource for delaying responses to client questions/contributions.

The oncologist's preference for completing the physical exam prior to discussing treatments can also have clinical relevance (as it may in the haircutting excerpt). For example, certain types of swelling at the surgical site can cause a delay in initiating adjuvant treatments, though it is unlikely to change the type of treatment recommended. Whether or not the information gathered from the physical examination is actually incorporated into the recommendation is an interesting question, though not within the scope of the current analysis. What is important is that the oncologist *presents* the activity of the physical examination as relevant to the discussion of further treatments. True, physicians may not want to lay out all of the possibilities for treatment only to find some insuperable difficulty at the surgical site, but they never make that clear to their patients; they simply say that they want to examine the site before discussing treatment options, consituting treatment topics as the capstone activity.

Questions Treated as "Unanswerable-at-the-Moment"

In the excerpts that follow, patient contributions or questions are treated as not relevant to some current activity. In this way, the oncologist invokes the potentiality of the agenda to serve as a postponement from, at the moment, an unanswerable or dispreferred question. Marking the patient's question as in some way "out of order" works to manage the direction of the talk, similar to how the hairdresser "overruled" the client's contribution in

favor of continuing her assessment of the state of the client's hair. In the case of the haircut, the client's emergent contribution was actually deleted. In the oncology setting, there is no evidence in these data that patient concerns are fully deleted, but they are delayed, and patients similarly do not pursue their queries once their contribution has been treated as out of order.

In excerpt 5, the oncologist attempts to redirect the talk as the patient moves to go outside of the confines of the activity at hand. The oncologist has been covering general medical history and demographics and has just asked the patient if she works outside the home. She says that she has worked as a consultant. At line 165 the patient then says:

Excerpt 5

- 165 PT 59 ↑That's↑ another question when I go through
 166 treatment am I going to be able to work.
 167 DR 7 Well lemme- what I plan on doing (.) i:s I
 168 wanna (.) get this information from you, I do
 169 want to examine you briefly just to (.) check
 170 things over, and then we'll go through. The:: uh
 171 thee answer to that would be: yes uh:::
 172 PT 59 [Cuz I've got
 173 DR 7 [+There may be some+ (.) changes have to make but in general
 174 people can continue to work if (.) ya hafta make some scheduling
 175 changes usually.=
 176 PT 59 *=I've got some good interviews coming up (☉next week☉)heh.*
 177 DR 7 (Good.) What sort of work do you do?
 178 HU 59 I'm a banker.
 179 (3.0)
 180 DR 7 A:::ll right. Now your health generally been good?

At line 165, the patient refers back (with the word "another") to the doctor's initial invitation much earlier in their talk to disclose the reason for her visit and to outline her concerns and questions. The patient's question, "Will I be able to work" is direct, setting up the relevance of a "yes" or "no" answer. In contrast to the earlier examples, this is not requesting an opinion so much as setting up the relevance of a categorical response. This highly focused, direct question is treated as out of order and is revealed as such by the doctor's response (lines 167–170) in which he displays a dispreferred stance toward the question. The "well lemme" that launches his utterance can be indicative of some form of disagreement to come (Pomerantz 1984) and his emphasis on the first-person pronoun in line 167 is implicitly in contrast with some other person's plan (for discussions of contrastive stress in English see Lakoff 1971; Sacks 1995).⁶ The oncologist is apparently contrasting what *he*, the doctor, wants to do with what the patient might want to do. Despite this apparent trajectory away from the patient's question, the oncologist answers her question in line 171.

Thus, although the doctor answers the patient's question, what is important to note is how he significantly delays his response. In essence, by overtly stating his plan of action and by delaying his response to the patient's question, the doctor initially moves to disallow it at this time. As noted in the family gathering excerpt presented in the introduction to this article, a participant may display a stance of reluctance to take up a topic yet still provide an answer. In a similar fashion, the oncologist in excerpt 5 displays reluctance to take up the patient's question and does so by utilizing the resource of the clinical agenda, lay-

ing out items that need to be attended to first. He effectively puts off her question “for the moment” and marks it as out of order.

What is curious here is the way in which the patient moves to provide an account for her concern about working (“Cuz I’ve got” at line 172). This type of adverbial clause initiator, in a new intonational unit, is clearly not in pursuit of response (she has gotten a “yes” answer) but shows that the patient means to qualify or elaborate on the background to her previous utterance (Ford 1993, pp. 104–124). There is an indication that some further talk may be coming (the doctor’s “uh:::” at the end of line 171) and, during a split second of speaker-exchange space, the patient takes the opportunity to embark on the project of clarifying—only to be overlapped with the physician’s continuation of his clarification.

A few possibilities present themselves as to what the patient’s account (that she eventually gets in the clear at line 176) is doing. It may be providing necessary detail to show that her initial question (“Will I be able to work”), which was treated as untoward by the oncologist’s preceding talk, had some import, that it wasn’t just an everyday concern but was related to something significant. Or the patient may be orienting to the oncologist’s display of turn continuing (after his “yes”) as some qualification on the “yes” response, and she wants to head off any unwelcome news with her account. The fact that she persists in getting her account into the clear at the next opportunity (after she has heard the clarification) may weigh in on the side of her providing an account for her “interruption” to the medical history taking. She ends her account of the “good interviews” in a smile voice and with a laugh token, perhaps displaying some awkwardness or troubles resistance (Jefferson 1984) at this moment. The oncologist provides a positive assessment (“Good”) and, linking back generally to the topic they had left off, asks the husband what work he does. This question is “out of the blue” but works to recalibrate the turn taking sequence to an interview format. The husband’s response is left without further assessment and the participants continue with the medical history interview. Note the elongated “Alright” (line 180) which is hearable as moving the talk forward.

Overall, it seems as though the patient provides a post-positioned accounting for her initial question. Had an affirmative answer been enough, that “yes” she could work, there wouldn’t seem to be any relevance for her persisting with the account. At the very least, she is orienting to her question (given the doctor’s response) as in need of some further work to maintain the appropriateness of it at that moment.

In excerpt 6, the oncologist moves to shift out of the topic of treatment options (that he himself has initiated) after the patient raises an implicit resistance to chemotherapy. This visit began with the oncologist eliciting medical information and then moving to a general discussion about chemotherapy, a topic that is canonically ordered after the physical exam when treatment options are discussed in detail. When the patient makes a topically coherent contribution, framed as a question about alternatives to chemotherapy, the oncologist moves to delay the discussion, promising to return to the topic after the exam. Again, mentioning the physical exam marks the patient’s question as “premature.”

Excerpt 6

212	DR 10	... ih it's kind of (.) therapy to prevent the
213		problem instead of treating the problem after it
214		comes up.
215		(1.5)
216	PT 96	Well (is there) <u>other</u> treatment besides <u>this</u> type
217		of (0.5) er doctor [Mc] he <u>explained</u> to me- he <u>told</u>

218		me, (1.0) that (.) he- if I <u>needed</u> it, he would give
219		me chemotherapy or, 8I could take a pill.8
220		(2.0)
221	DR 10	There- right there are, there are other, uh, not <u>all</u> of
222		this adjuvant therapy is <u>chemo</u> therapy=some of it is is
223		hormonal therapy for [example.
224	PT 96	[uh huh,
225		(2.0)
226	DR 10 →	Why don't I examine you though and then we can
227		talk more about
228	PT 96	Okay.
229	DR 10	about what we definitely would recommend in
230		your case.
231	PT 96	Okay.
232	DR 10	Okay?
233	PT 96	mm?
234	DR 10	There should be a gown for you in the back room
235		there.
236	PT 96	Alright.

In excerpt 6, the patient raises an implicit resistance to chemotherapy by asking a question about alternative treatments (“a pill”) she claims to have heard about from another doctor. Though this is a relevant contribution at this sequential point in terms of the *content* of their current discussion, and the doctor answers the particular query, apparently to the patient’s satisfaction, he nonetheless displays an orientation to managing an agenda for the visit, promising that further information will be forthcoming.

The patient’s question in this instance is not only direct (“Is there other treatment besides this”) but is also bolstered by a third party attribution: “Dr. [Mc] told me. . . I could take a pill” (lines 216–219.) In contrast to the previous example in which the patient’s direct question was at first treated as delayable, this oncologist answers this patient (lines 221–223). This may be locally contingent on the attribution of the observation about treatment to another doctor—such an attribution may require immediate attention from a fellow oncologist, but it is not elaborated upon. Despite the initial answer and the patient’s uptake of that answer (“uh huh” at line 224) which is hearable as a continuer (turning the floor back to the doctor for further talk), the patient’s contribution is followed by a two-second pause (line 225). The doctor takes the opportunity to introduce the activity of the physical exam, projecting that there will be more talk about the patient’s specific case after that. His use of the word “though” (line 226) indicates a contrast: rather than further their discussion of types of therapies at this point, he would like to establish a different order, that is, proceed to the physical examination and take up specific concerns later on. The patient displays no resistance to that plan (lines 228, 231, 233, 236).

While in line 224, the patient’s stance might be characterized as receptive to further information or explanation about alternate modes of treatment, she doesn’t pursue this topic. She accepts the physician’s choice for the direction of the talk. Interestingly, this patient never actually gets a firm recommendation during the course of this visit. After the physical exam, the doctor explains that he must confer with his colleagues about the patient’s case. This is apparently due to some missing information from her file, not to anything that comes up during their discussions. Although the oncologist seemed to know from the out-

set that he would not be able to offer a firm recommendation to this patient—they discuss early on in the visit the information that is missing—he never explains this to the patient. In other words, physical exam or not, the outcome of this visit would have been the same. Thus, it seems that delaying the patient's question in this case is related more to obviating direct inquiries about treatment prior to the physical exam than to anything of apparent clinical concern.

What we have seen so far is that the oncologists in these interactions invoke an agenda of activities and topics they want to get through in a particular order. Invoking the agenda (as we see in excerpts 5 and 6) works to postpone some patient-initiated topics or retroactively mark the patient's questions as out of order or premature. In this way, the agenda can be used as a resource for managing the direction of the talk. Patients cooperate in constructing the visit as proposed by the physician by not pursuing treatment-related topics once they've been marked as delayable.

In another example of this type, though not invoking the medical agenda specifically, the oncologist defers a question by promising to answer it later and carries on with the current activity of gathering medical and demographic information. In excerpt 7, the oncologist has asked the patient about the results of her progesterone receptor test. The patient responds that her progesterone receptors were positive but doesn't recall the exact numerical value. Her husband then asks the oncologist to address the significance of the receptors.

Excerpt 7 (HU = Husband)

- 216 PT 30 But it it was positive.
 217 DR 4 Okay. Now'
 218 HU 30 'Can can [you uh (.)
 219 DR 4 [How are you ah
 220 HU 30 expound- that's one of the questions, expound upon
 221 the significance of that.
 222 DR 4 Yeah [I'll uh
 223 PT 30 [He'll get-
 224 DR 4 I'll go into that [in a
 225 PT 30 [yeah.
 226 (2.0)
 227 DR 4 in a fair amount of detail.
 228 PT 30 ([)
 229 DR 4 [Uhhh, what that means. Now, uhm
 230 (4.5)
 231 You're forty-one?

Again, the doctor is asked directly to address a concern (in this case raised by the patient's husband's question, "Can you expound on that," at lines 218–221.) The doctor promises to address the question (line 224) but for the moment turns the agenda to collecting medical history (line 231). Note how the patient aligns with the doctor: her utterance at line 223 looks as though it's on its way to predicting the doctor's statement at line 224. The patient thus cooperates with the doctor in voicing (to her husband) the "promise" that an answer will be forthcoming at the appropriate time. In this way, the patient constructs herself in the institutional role that is usually thought of as "the doctor's." She presents herself as a participant in the institution, displaying an understanding that information will be forthcoming. So it is actually the husband who is being asked to wait—by the patient and the doctor. Indeed, the patient, through her talk, "takes on" or "shares" the institu-

tional mantle of gatekeeper simply by projecting what information is to come, how the visit is to unfold.

The role of estrogen receptors in determining prognosis is returned to in a sporadic way later in the encounter after the physical exam. Whether or not it is done, as promised, in "a fair amount of detail" remains an open question.⁷

DISCUSSION AND CONCLUSION

Collaborative orientation to an agenda of activities is not unique to medical settings. It is a characteristic of everyday interactions in which one participant mentions an activity (or set of them) to be accomplished and other participants can, and sometimes even do, cooperate. In institutional settings where there is a service or advice to offer, the canonical agenda of activities may be used as a resource for getting the participants oriented to the overall goals of the interaction and can be used to forestall activities that, apparently, the service provider prefers to delay. The example from the haircut appointment is a reminder that the phenomenon under investigation is not original with or limited to doctors and patients; nor do I assume that it is restricted to professional encounters.

Since there may or may not be clinical relevance to the forestalling of patient questions, one might ask, "why that there?" For some reason, the physician marks certain patient queries and topics as delayable, proposing instead to continue with a set of clinical activities. The stalling move displays that the oncologist indeed has some information to impart but can choose when to do so. Thus, the postponement of client contributions and the client's cooperation in that delay (by dropping pursuit of response) creates an observably and locally produced asymmetrical relationship in which one participant establishes the order of activities; asymmetry of knowledge and task is thus made visible (for a review regarding distribution of tasks in medical encounters see ten Have 1991). Furthermore, such a move instantiates the physician as the one in control of sought-after information.

In those instances where a patient's questions take precedence and thus the patient's "agenda" (in the sense of topics she wishes to cover) supercedes, it is still the physician who ultimately returns the interaction to the canonical order of events (excerpts 5 and 8) or proposes such an ordering of activities (excerpt 6). Importantly, while physicians move to delay topic proffers or questions, patients, at least in these data, never engaged in such a practice. There was no evidence here of a patient replying to a doctor's question with, "Well, first I'd like to do X, then we can talk about Y." Thus, by interrogating how interactants accomplish and make recognizable their roles to each other, we have a better understanding of category-bound activities on which members draw to produce observable and reportable features of interaction (Sacks 1972). That is, invoking the sequence of clinical activities to be accomplished seems to be in the province of "doctors' work." If a patient were to engage in such a practice (and this is of course just speculation until recorded examples are available) then one would expect to notice some accounting for that, or disruption, hesitancy, or sanctioning of such an action as being incongruous. As proposed by Harvey Sacks (1972), category-bound activities allow members not only to engage in search procedures to know "what is happening here" but also to recognize when something is "off," strange, or being breached in some way.⁸

In the discussion of exemplars from the oncologist-patient interactions, I assumed that questions and answers are social actions rather than linguistic forms, that is, they are sequentially related (Schegloff 1972; Schegloff and Sacks 1973), a questioning action pro-

viding for the “relevance” of an answering action (Schegloff 1972, p. 76). Yet, as we know from experience and from these data, not all questions are answered as they arise. If an unwelcome question is raised, co-participants can (and do) find ways to avoid the relevant obligation of answering. But such a “putting off” could potentially be a delicate matter, particularly in a service encounter in which information is sought and expected. To be too long “put off” in such a setting, or perhaps in any setting, may result in irreparable disruption of the relationship. Thus, if a physician prefers not to answer a question (for whatever reason), he or she has must have recourse to a conversational mechanism for that sidestepping action; this seemed to be the function of invoking the clinical agenda.

That health professionals construct the medical encounter as an agenda-based meeting has been demonstrated in detail by John Heritage and Marja-Leena Sorjonen (1994) through their analysis of “and-prefacing.” The interactions examined for the current study extend their analysis to show how the clinical agenda—“what we’re engaged in here”—can be invoked by the health practitioner as a resource for maintaining control of the interaction, such that inopportune topics can be delayed. Thus, it seems that we are moving toward an enriched understanding of the sociology of medical work by analyzing how “contexts of institutionality” (Silverman 1998, p. 167) are created by participants themselves in the moments of their coordinated activities. On a more practical level, and as discussed by Silverman (1997, pp. 209–225) in the context of research on HIV counselling, by understanding how medical encounters are organized through the details of talk-in-interaction, skills training for practitioners and patients can begin from actual behaviors rather than from theoretically based normative rules. Such an approach necessarily presupposes a greater focus on the details of the sociology of work (and patient-provider relations) and presents opportunities for improving clinical practice and client education.

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APPENDIX 1

Transcription Symbols

.	Falling, “final” intonation as at the end of a sentence
,	Continuing, “comma” intonation as in speaking a list
?	Rising intonation
:	Sound stretch; usually elongation of a vowel
CAPS	Louder than surrounding talk
* *	Reduced volume between these signs
+ +	Faster speech between these signs
—	(underline) Stressed element

↑↑	Speech between these signs is hearable as higher in pitch
☺	“Smiley face” indicates that speech between these icons is said with a “smile” voice
(.)	Untimed “micropause” (less than half of a second)
(1.0)	Timed pause, represented in seconds
=	Talk that is latched, quick continuation; no space or overlap between the utterances
[Marks onset of overlap
-	(hyphen) Speaker cuts off own speech
()	Transcriber doubt
((sniff))	Untranscribed sound
...	(horizontal or vertical) Ellipsis

NOTES

1. This analysis did not begin with the research question formulated here. Rather, a phenomenon was noticed (physicians delaying answers to patient questions) and as that phenomenon was analyzed in detail and comparison was made to instances where patient questions were *not* delayed in any way, it began to emerge that this action of delaying questions and patient nonpursuit of answers was in some way part of the collaborative work that gave a sense of asymmetry and purposefulness to the interaction.

2. The analytic intractability of “questions” in medical encounters is discussed by ten Have (1991) in his treatment of patients’ formulation of their “ignorance” as a covert information-seeking strategy. In brief, setting limits on the category “question” has been shown to be a highly problematic linguistic construct, so as I refer to entities as “questions” I do so fully aware that such a label glosses other activities at hand. I believe, however, for the current study, the analysis is not severely compromised.

3. An “insertion sequence” (Schegloff 1972) is a sequence or series of actions that fill the space between a first pair part (e.g., a question) and the second pair part (i.e., the answer). An “insert expansion” can be in the service of clarification or to collect further information (Schegloff 1990, p. 64) in order to be able to respond to the first pair part. For example, in emergency calls, the operator may respond to a call for help with a series of questions to clarify where the help is needed and how quickly (Zimmerman 1992). In the current data, I am characterizing the oncologist’s move as a “pre-insert expansion” because he or she verbally points to intervening material (e.g., physical examination) as an activity to come that ostensibly will clarify the medical situation and assist the physician in providing a better answer to the patient’s question.

4. That the physician invites the patient to ask any further questions is not necessarily relevant to the fact that he provides a response. In all of these clinic interactions, patient questions and concerns are elicited by the oncologist (Roberts 1999), but some are answered in the moment and others are delayed.

5. Schegloff (1987a, p. 110) writes that one speaker “sequentially deletes” a turn by another in a particular stretch of talk in that “it treats [the other’s turn] as sequentially nonconsequential.” In essence, the turn (which was an addition and contrast to a prior remark) is “ignored, treated as a non-event.”

6. Lakoff (1971) shows that comparisons and contrasts are marked by stress in English and that correct formation/comprehension of such sentences requires extralinguistic (i.e., pragmatic) knowledge. Lakoff regards contrastive stress as a presupposition trigger, a linguistic construction that indicates what kind of inference is to be made (namely, in this case, a comparative). Sacks (1995) discusses how speakers use intonation to position an utterance relative to something other than the last utterance. Sacks (1995, 2:558) provides the following: “. . . you can do a thing like ‘I went to the

movies' where the contrast stress on 'I' provides for locating *some* prior utterance, not necessarily the last, which this one by reference to its contrast stress intends to be in contrast to."

7. The husband's question is never specifically referenced after the physical exam. However, the oncologist makes the following three remarks over the course of his talk (a nearly uninterrupted 10 minute stretch of talk explaining treatment options. The substance of these remarks is similar to what oncologists usually say with regard to estrogen receptors): "The fact that your estrogen receptors are positive is good." "The idea being that patients with positive hormone receptors tend to be the patients that respond to hormonal treatments when their cancer recurs." "The fact that your hormone receptors are positive tends to suggest that you have a slow-growing tumor."

8. For a discussion of the debate surrounding the use of membership categorization analysis, see Silverman 1998, pp. 128–152.

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