Talk and Institution: A Reconsideration of the "Asymmetry" of Doctor-Patient Interaction

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The idea that interaction between physicians and their patients is "asymmetrical" is widely shared among both participants and observers of medical encounters. It is assumed as a "social fact" that the roles of doctors and patients differ, and that this difference corresponds to that of leaders and followers. This "fact" has been explained in various ways by contributors to medical sociology, whether causally or functionally, but it is only during the past ten years or so that research has been directed to the details of the interaction that are masked by a gloss such as "asymmetry." The accumulated findings of this research, and further work along these lines, can contribute to a radical reassessment of conventional reasoning regarding institutional behavior. While traditionally the asymmetry of doctor-patient interaction was considered as an effect of institutional structures, rules or resources, it now becomes possible to think the other way around, in the manner developed over the years by ethnomethodology, and see how asymmetries are produced *in and through the details* of physicians' and patients' situated interactions. In this chapter, I will show some of the ways in which participants in medical encounters "talk an institution into being" (Heritage 1984a: 290) and thereby accomplish "asymmetry" (see also Heritage and Greatbatch, 1991).

Medical encounters are tightly organized events. At one level, they display a rather conventional organization in terms of phases devoted to specific consecutive tasks in the encounter, i.e. complaint presentation, verbal and physical examination, diagnosis, and treatment, prescription and/or advice (see also Heath 1986). But, on a more detailed level, this overall organization has to be realized through series of concerted activities that are sequentiallr. organized. This chapter is focused at this more detailed level. It is there that "asymmetry" seems to be produced. But it will prove useful to reconsider the connections between these two levels of organization at various points in the argument that follows. I shall want to argue that locally organized sequential events contribute to the phased organization of the encounter as a whole, but that they are also framed by it.

In the discussion that follows I will explore and elaborate on general aspects of the constitution of asymmetry in doctor-patient interaction, drawing on two resources: (1) research findings of authors like Fisher, Frankel, Heath, Mishler, Todd and West, who have studied medical interactions in detail, and (2) my own work on general practice consultations in the Netherlands (ten Have 1987). To say that doctorpatient interaction is asymmetrical implies that two kinds of comparison are made. First, there is a comparison of what is done, and what may be done, by physicians and patients respectively during the encounter. Secondly, those asymmetries are compared with a model of symmetrical interaction assumed for informal conversation among peers. In other words, characterizations of medical interactions typically tend to contrast the action repertoire of doctors and patients and then contrast this pattern with ordinary conversation. While these comparisons may be analytically helpful, one should resist the temptation to accept these contrasts, especially when stated in absolute terms, as adequate empirical descriptions. In fact, both the differences in behavior between physicians and patients, and the differences between consultations and conversations are relative, changing from one occasion to another and from one moment to the next. It is only in their actual dealings with each other that participants in medical encounters "produce" asymmetry in various ways and to a variable extent. Institutional structures are not only external constraints on participants' actions; they are also actively used as a resource for those actions (cf. Maynard, chapter 7 below).

The contrasts mentioned are used primarily analytically and descriptively, but moral

overtones are not always absent. It seems that a "morality of equality" is hard to avoid and more symmetrical or conversational forms of interaction are somehow preferred. On the other hand, it may be argued that making consultations more like conversations would either tend to be a hypocritical masking of unavoidable asymmetry or would actually destroy the consultation as such. While this is certainly an interesting debate, I for present purposes I will try to avoid it. Following a policy of "ethnomethodological indifference" (Garfinkel and Sacks 1970), no moral judgments are implied in my use of the contrasts, although some of the authors I discuss – especially Mishler – either implicitly or explicitly tend to introduce such judgments into their contrasts.

Aspects of Asymmetry

Basically, asymmetry in doctor-patient interaction is of two kinds. First, there is an asymmetry of topic: it is the patient's health condition that is under review, not the doctor's. Associated with this, there is a second kind of asymmetry: of tasks in the encounter.

Patients' tasks mainly involve reporting their symptoms, answering questions, and accepting physicians' decisions, while doctors are supposed to listen to complaints, to investigate the case, and to decide on a diagnosis and a treatment. Although the initiative for the encounter is primarily the patient's, this task distribution involves quite "natural" interactional dominance by the physician, enacted through questioning, investigating, and decision-making behavior, coupled with interactional submission by the patient, achieved through answering, accepting and generally complying with the doctor's orders and suggestions.

Recent research in the details of medical interaction, including my own work (ten Have 1987), would seem to support general conclusions such as the following:

1 Local initiatives that establish a conditional relevance for specific kinds of second actions, such as questions, orders and proposals, are mostly taken by physicians and seem to be "dispreferred" when taken by patients (Todd 1984; West 1984:71-96; Frankel 1990).

2 The interactional control that seems to follow from this is reinforced by restrictive ways in which these initiatives are often used, especially by questions that allow for only short factual answers (Frankel1984, 1990; Mishler 1984:59-91).

3 Questions put by physicians come mostly in series, in such a way that answers by patients are enclosed in and framed by the doctor's contributions: that is to say, the preceding question and the acknowledgment that follows it, and/or a next question, that in many cases comes interruptively (Frankel1984, 1990; Mishler 1984:59-91; Todd 1984; West 1984:53-64).

4 The questions themselves, together with their topical flow and topic changes, are generally not accounted for by physicians; in particular, motivation for physicians' questions is not provided, and topic changes - which may be initiated quite abruptly - are not marked as such (Mishler 1984:95-121). In this way the patient is not informed on the reasoning process that supposedly guides the doctor's actions.

5 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 (Atkinson 1982; Frankel 1984; see also Heritage and Greatbatch, 1991, Maynard, 1991).

6 These tendencies often seem to be instrumental in a noted biomedical selectivity in that

physicians tend to ignore those aspects of patients' utterances that report on subjective experience, personal circumstances and social conditions (Frankel 1984; Mishler 1984; Todd 1984). Elliot Mishler (1984:164) has called this a "context stripping" approach. An important exception to this tendency is found in those cases where the physician specifically focuses on context in an approach that stresses psychosomatic aspects of diagnosis and treatment (ten Have 1989).

7 Finally, the asymmetries mentioned will accumulatively, so to speak, result in a tendency for decisions that are mainly based on the doctor's perspective on the case, guided by his questioning and relative lack of knowledge of the relevancies stemming from the patient's orientation to the problem (Paget 1983; Fisher 1984; Todd 1984). That is, in all the above instances, it takes specific efforts on the part of patients to counter tendencies leading to such a result, unless physicians take steps to provide them with occasions to influence the proceedings.

In essence, then, the literature reviewed suggests two major trends in the interactional style taken by physicians in their dealing with patients, one of monopolizing initiatives, and another of withholding information. Studies of medical interaction have, as their major focus, the phases of the consultation producing data, especially the physician's questioning of the patient. Questioning is analyzed as a series of two-part or three-part sequences: a question followed by an answer, with the optional addition of a "third turn component" by the questioner (cf. Frankel1984). In the following sections, I discuss some aspects of the ways these sequential possibilities are used by the participants, that is how "asymmetry" is locally produced or circumvented. In so doing, I will not only consider cases that conform to the major trends, summarized above, but also instances that run counter to those trends.

Asymmetries of initiative

Generally, as noted, patients take the initiative for the encounter as such: it is their decision to consult at this specific moment. Within the encounter, however, they seem to "lose" this initiative when the doctor's questioning takes over. It is this "takeover" that is of special interest in studying the accomplishment of "asymmetry."

While patients may decide if and when they come to their physician's consulting hour, it is the doctor who decides when they may enter his room. When inviting a patient to enter, a doctor acts like a host, inviting the patient to sit down and - possibly after some small talk - to provide the reason for his or her visit. In the initial invitation, the physician may refer to what he remembers or reads in his record concerning previous visits (cf. Heath 1981, 1982). But, in the data for my study, typical invitations are quite direct: "Venel het es," which amounts to "What's up?" or, more literally, "Tell me what it is." The "it" here appears to refer to the reason for the visit. In new cases, the patient will typically explain his or he

Excerpt 1 ((A = Physician, P = Patient))

9 D vertel het es
10 P ja ik ben zo geweldig aan diarhee en 't wil niet over gaan

9 D what's up

10 P yes I have so much diarrhoea and it won't go away

As can be seen, such a statement does not formulate a request, it states a reason for coming to the doctor and provides him with material for his upcoming questioning. In this way it functions as a request for diagnosis and/or treatment (see Wilson, 1991: 33-4). When specific request forms are used, they tend to implicate a specified check-up, as in the following instances.

Excerpt 2a

7 P e:h kunt u kijken of ik zwanger ben
8 (0.4)
9 P (ghh)

7 P u:h can you check to see if I am pregnant
8 (0.4)
9 P (ghh)

Excerpt 2b

27 P ja daar zitten we weer heh
28 D daar zitten we weer ja
29 P ik heb t'r nog twee dingen bij dat e:h moet u dus even naar kijken
30 D en dat is
31 P (eerst es) naar m'n keel (1.2) en naar deze knie

27 P yes here we are again huh
28 D here we are again yes
29 P I have two more things that uh you have to take a look at for a moment
30 D and that is
31 P (first uh) at my throat (1.2) and then at this knee

In responding to the doctor's invitation in this subdued way, patients defer to the professional to decide what should be done next, whether a diagnosis and/or treatment is necessary and/or possible. These first utterances of the complaint also specify the body region that deserves his attention. Thus, patients provide their doctors with material for questioning in their very first utterances and physicians get an opportunity to "take back" the initiative they gave their patient just one moment ago (see also Wilson, 1991).

Both patients and physicians thus contribute to the start of an interaction format, namely questioning, that is oriented to the establishment of medically relevant facts. Within this format, the physician has the initiative and the patient is restricted to a responding role. In some cases, however, one can observe the emergence of a different format oriented to the history and the larger context of the complaint(s), rather than to just the facts. This format implies a more active role for the patient, as a teller of his or her own story. Extract 6.3 may be considered as an instance where such an alternative format is seen to emerge.

Extract 3

17 D dat is een hele:: hh ‘h geschiedenis met jou
18 D geweest in eh januari heh
19 P ja ( )
20 (.)
21 D en dat is toen dat is (.) sindsdien goed gegaan?
22 P ja
23 ((interrumperend telefoongesprek))
24 P (‘t is namelijk zo) ik ben al een paar maanden (.)
25 P verkouwen en dan is ‘t weer over en dan is ‘t weer weg
26 D ja
27 P en eh zondag kree’k in een keer eh (.) goed hoofdpijn
28 D ja
29 P (‘k moest helema-) aan aan deze kant helemaal
30 D ja
31 P en zondagavond kree’k eh pijn in m’n borst hier
32 D met hoesten of zo of nou-

17 D that has been quite a history with you in uh
18 D January huh
19 P yes ( )
20 (.)
21 D and that has then that has been (.) going alright in the mean time?
22 P yes
23 ((interrupting telephone call))
24 P (it’s just that) for a couple of months I had
25 P (.) a cold and then it was over and then it wass gone
26 D yes
27 P and Sunday I s*u*ddenly got uh (.) a real headache
28 D yes
29 P (I had to all-) on all over this side
30 D yes
31 P and Sunday night I got uh pain in my chest here
32 D with coughing or something or whatever-

We have entered the consultation at the moment the physician finishes reading the patient’s record card. Presumably referring to the last entry, he displays an interest in the sequel to the “history” he finds recorded there (line 21). In other words, he provides for a story to be told. The patient, then, does tell a story of sorts (lines 24-31). It is a tightly organized “unit” (cf. Houtkoop and Mazeland 1985), especially in the sense that the earlier parts display their own incompleteness, that is, that the major point, what may be called the “pressing complaint,” is yet to come. This is achieved in a number of related ways:

1 by starting earlier in time (line 24), thus suggesting that the very reason for the present visit has not yet been discussed;
2 by mentioning relatively permanent states (lines 24-5), this effect is strengthened,[4] suggesting its status as “background information”;

3 by adding a second item (line 27) to a previous one (line 24), it is suggested that a "list" is being constructed, which again heightens the expectation of more to come, that is, a third item to the list (cf. Jefferson 1990 on lists in casual conversation, and Atkinson 1983, 1984, on lists in various other contexts).

While in this case interactive structuring by the physician and the patient seems to complement and facilitate the production of a fuller historical account, this need not always be the case. Physicians may suggest fuller accounts, while patients stick to "just the facts," as well as the other way around. In the latter instance, patients are observed to use devices, those mentioned above and others, to change their local interactional identity from that of a "respondent" into that of an "informant."[5]

What these observations indicate is that although patients generally play their submissive part in the established "asymmetrical" format, possibilities also exist for patients to extend their chances to bring in materials on their own, which are sometimes successfully used. We should note that the devices for doing so are quite ordinary ones, regularly deployed in casual conversations (cf. chapter 1), as well as in various other settings. What is noteworthy, however, is their "covert" character: they seem to hide their action potential, the initiative their user is taking. In other words, patients seem to disguise their interactional initiative by refraining from formulating requests, by giving the initiative back to the physician rather quickly, or by using quite subtle and covert devices to hold off the doctor's questioning interventions.[6]

Questioning

Most researchers who have studied doctor-patient interaction in detail have given their primary attention to questioning sequences and consider the doctor's handling of these sequences as their primary instrument of interactional control. The central idea, summarized above, is that physicians have a privileged access to the first position in such sequences, which gives them control of what can coherently be said in the second position as an answer, and provides them with a possibility to come back after a minimally complete answer with a third position item, or a next question. In this way access to the first position is seen as a major entry into interactional control (see also Wilson, 1991; Heritage and Greatbatch, 1991).

In this section, I will consider the concept of asymmetrical questioning *per se,* while in the next I will focus on some uses of the third position within it. The thesis of a dispreference for patient-initiated questions was, to my knowledge, originally developed by Frankel (1990). This concept was also used in a study by West in her analysis of 21 family practice consultations (1984; see also West 1983). West examined all questions that figure in this collection; most, 91 per cent of the total number asked, were initiated by the physicians, and these were also more successful (98 per cent versus 87 per cent answered). But West does not restrict herself to such an overall quantitative analysis. As she writes:

> Stronger evidence for the dispreferred status of patient questions is furnished by closer inspection of the form they take. In the course of this analysis, I assembled a collection of all patient-initiated questions from these exchanges. What is most striking in this collection is the presence of marked speech perturbations in the speech objects used by patients to construct their queries. . . . In fact, of the total of 68 questions posed by patients, 46 per cent (31) displayed some form of speech

> disturbance in the course of their production. Put simply, patients displayed considerable difficulty "spitting out" their questions. (1984 :88-9)

She continues, later: "By and large. . . physicians' formulations of questions exhibited little evidence of speech disturbances" (West 1984:168).

Although I do not want to dispute the general thesis of a party-bound preference or dispreference for questions in consultations, I do have some difficulties with this research. Firstly, in my view, the analytic category of "question" is a difficult one. Although West (1984:73-80) deals briefly with some problems, I also see others. For instance, in my observation patients very frequently formulate their "ignorance" or "doubts" in various medical matters. These utterances do not have a question form and do not create a "conditional relevance" for an answer in the next slot. But they do display what the patient would like to know, or on which issues he or she would like to have an expert's opinion. Such utterances are often ignored by the physician, but sometimes they are taken up, possibly much later in the encounter, as in the next example:

Extracts 4 (from the same consultation as 3)

51 P 'hh ma- 'k ben gister expres een beetje op bed
52 P gebleven ik denk 't zal wel iets van kou zijn ik heb die-
53 P (.) die- in laten smeren met dimedalgam heet dat=
54 D =dimidalgam (.) ja dat is tegen spierpijn (en [zo)
55 P [ja maar dat
56 D 'h[h dat helpt ni[et
57 P [e:h [(helpt) weinig
.....
96 D want ik hoor d'r niks aan (.) in je longen (.)
97 D aan de binnekant is d'r niks (.) en eh je hoest ook niet
.....
126 D ik denk dat het toch eh die dat 't iets is met
127 D spieren [wat je daar hebt heh die pijn 'hh dat 't
128 P [(merkwaardig)
129 D een soort e::h spierpijn is

51 P 'hh but- yesterday I especially stayed in bed a bit
52 P I think it is something like a cold I have di- di-
53 P (.) di- let it be smeared with dimedalgam it's called
54 D dimidalgam (.) yes that is for muscular pain (and [such)
55 P [yes but that
56 D 'h[h that doesn't [help
57 P [u:h [(that doesn't help) much
.....
96 D because I don't hear anything there (.) in your lungs (.)
97 D there's nothing inside (.) and uh you also aren't coughing
.....
126 D I do think that after all uh that that it's uh pain
127 D something in your muscles [that what you have there

128 P [(strange)
129 D ‘hh that it’s a kind of uh muscular pain

The physician, in this case, can be seen to check the two lay diagnoses that the patient reports to have considered earlier (lines 52-3), concluding that the first cannot be confirmed while the second is plausible.

In other words, it is difficult to set clear limits on the category of “question.” Patients have a variety of ways in which they can make known to their physician their informational needs. Moreover, some of these more covert “questioning” approaches would be unlikely candidates for inclusion in West’s analysis, although they may, in fact, be quite practical ways of getting physicians to provide desired information.

Secondly, while many questions put by physicians have a constraining effect on what *may* be coherently said as an answer to them, this is not *necessarily* the case. Although many questions provide for only yes/no or other kinds of short and factual answers, others specifically leave it to the patient to structure his or her report in the manner he or she sees fit (see also Maynard, 1991):

Excerpts 5 (from different encounters)

13 D waar dacht je zelf aan?

32 D waar kan dat nou vandaan komen denkt u?

38 D e:n hoe komt-tattan?

43 D wat is dat allemaal?

118 D hoe ging het verder met u de laatste tijd?

179 D hoe voelt u zich verder?

13 D what are you thinking of yourself?

32 D where does that come from do you think?

38 D a:nd how does that come about?

43 D what is that on the whole?

118 D how are you going beside that lately?

179 D how do you feel beside that?

In other words, West’s analysis, by not differentiating as to the amount of control exercised by questions, runs the risk of overstating the interactional restrictions actually imposed by physicians.

Thirdly, also lacking in this type of research is a consideration of the sequential environment in

which the objects under review are used. Specifically, I want to suggest that a dispreference for patient-initiated questions is most strongly present in the data-gathering phase at the beginning of the encounter. In that phase, a period of rapid and restrictive questioning – labelled "differential diagnosis" in the professional jargon of physicians – is often found. At other times during the consultation, however, and especially after the physician has stated his conclusions regarding diagnosis, treatment or advice, patient-initiated questions seem much less dispreferred or not at all. In fact, in my data, most patient questions posed in the environment of what I call the acceptance are uttered without any disturbance or other displays of a dispreferred orientation.[7]

In summary, I am proposing that while a questioning format is dominant in the data-producing phases of most medical encounters, and patient-initiated questions are largely dispreferred then and there, this should not be generalized to suggest that patients are automatically, so to speak, restricted in their possibilities to give and request new information throughout the encounter. Physicians can moreover frame their questions in ways that are less restrictive, and patients can use their answering slots to provide new information or suggest that they would like to be informed on specific points, as noted. Furthermore, the dispreference for patient-initiated questions seems to be phase specific. Patients have options to bring up their own points both before and after questioning, as part of their complaint(s) or as questions attached to the physician's decisions. West (1984:95-6) quotes Frankel saying: "It would be inappropriate to view the issues of control and responsibility in the medical encounter as properties of individuals," and she adds: "Instead, we are compelled to view such matters as micropolitical achievements, produced in and through actual turns at talk" (1984:95-6). Although in full agreement with these statements, I am suggesting that they be taken even more seriously than they have been until now. This is not to deny that physicians largely control the proceedings during medical encounters, but it is important to stress that this is not the automatic effect of institutional forms: rather it must be enacted by both parties and both of them have possibilities for less asymmetrical interaction.

Physicians' Uses of the Third Position: Assessments

Earlier, I summarized the literature on medical interaction as indicating two major trends in the style taken by physicians in their dealing with patients, one of monopolizing initiatives and the other of withholding information, at least during questioning. Having discussed the first trend above, I now turn to a consideration of the second. Atkinson (1982), Frankel (1984) and Heritage (1984 a and b) variously suggest that physicians and other professionals use "third turns" in quite specific ways when dealing with clients (see also Mehan 1979). Specifically, they tend to refrain from commentary, utterances displaying alignment, or any indication of their own information processing (see also Heritage and Greatbatch, 1991). Thus physicians, as well as other professionals, use two kinds of strategies, one active and one passive, to achieve an ongoing asymmetric display of knowledge, feelings and functioning.

Atkinson (1982) has suggested that a variety of routine utterance types - such as second assessments, second stories and newsmarks - are generally absent in professionals' contributions to lay-professional interaction; Heritage (1984 a, b) has also specifically noted the absence of "Oh" as a "change of state" marker in these settings (cf. chapter 5 at p. 109 above). Both authors maintain that the specific character of "formal" or "institutional" interaction is especially, but not exclusively, observable in such third turn usage. Heritage calls this – referring to Garfinkel – one of the "identifying details" of such interactions (see also Zimmerman 1984).

Researchers who have given attention to physicians' use of the third position report a variety of

turns such as acknowledgments, assessments, corrections and summaries (Fisher 1984; Frankel 1984; Todd 1984; Houtkoop 1986). Frankel, for instance, has analyzed over a thousand questioning sequences in the data-gathering phase of ambulatory care encounters. In over 60 per cent of them a third turn option was used. Dividing the utterances into two classes, acknowledgments and assessments, according to the absence or presence of contrast terms like good/ bad, right/wrong, etc., he finds that assessments were almost never used by physicians, accounting for less than 3 per cent of his cases. Acknowledgments, on the other hand, were very frequent and were mostly given in short forms like "uhuh," "okay" and "I see." And he . adds:

> One explanation for the large number of acknowledgements found in these data is that acknowledgements are used primarily to accomplish sequential as opposed to interpretive operations in discourse. Neutral third turn responses such as, "Mmh hmh," "okay," "I see," etc., operate without any obvious intrusion on the style or content of that which follows. Instead, their major effect is to invite speaker continuation by signalling receipt of prior information and nothing more. Assessments differ from acknowledgements functionally by introducing the speaker's reaction to, or interpretation of, the information supplied in an answer. (1984:157-8)

Generally, these tendencies roughly correspond to what I observe in my data from the Netherlands. Although perhaps to a lesser extent, Dutch physicians also seem to avoid assessments and newsmarks, for example. The fact that they do not always do so, however, offers the possibility of analyzing the exceptions. By investigating what may be done when such objects are in fact used, we may gain insight into what is accomplished by avoiding such use.

As a first approximation of such an analysis, I would like to propose a typification of episodes within medical encounters, as follows:

1 Episodes which have a marked "conversational" quality and in which non-medical topics are discussed, such as "small-talk."
2 Episodes which have a less marked "conversational" quality, which have more or less to do with medical topics, but are relatively marginal to the consultation's main "agenda."
3 Episodes in which the main medical agenda is being developed explicitly.

Quite often, in medical encounters, parties' talk does not continuously address the main topic(s) of the occasion, that is, the major complaint(s). In particular, immediately before or after dealing with their main business (type 3), parties tend to indulge in some non-medical small talk (type 1). This can also happen when the major activity does not require talking as such, for example during the physical examination (cf. Frankel 1983). Such occasions, especially toward the closing of encounters, can also be used by patients to elicit some minor medical advice, or to submit some medical idea of their own, even if it is not related to the major agenda (type 2). Elsewhere (ten Have 1987, 1989) I have tried to demonstrate that this variation in topic corresponds to a variation in interactional style. The style in type 3 tends to be the most formal, with type 1 the least formal in regard to such issues as the use of address terms, conversational restraints, and general asymmetry of interaction. In the following discussion we will observe a similar variation as regards the use of the third turn.

When objects like assessments and "Oh" -receipts are used in environments otherwise marked as

belonging to type 1 or type 2, they may be seen to contribute to a process which we may gloss with a term like "informalizing." The following instances may serve as examples:

Excerpt 6a

((during an "inserted conversation"))
1 P (nou ja) die verhuizerij da's natuurlijk een
2 P verv[elende (zaak)
3 D [da's een ramp=
4 P =o::h

1 P (well yes) that moving business that's of course a
2 P ted[ious (affair)
3 D [it's a disaster
4 P o::h

Excerpt 6b
((during the writing out of the prescription the patient has suggested that his colds are caused by the air conditioning at his place of work: the physician reacts as follows))

223 D e:hm (.) als-tie aldoor uit dezelfde hoek waait (.) 'hh
224 D als je staat (.) dus ik zal maar zeggen tegen die
225 D ze[re zij aan ['hh dat zou heel best kunnen ja (.)
226 P [hmm [hm
227 D ik vind het altijd waardeloos die air-conditioning=
228 P =ik v:- ik heb ter een bloedhekel aan

223 D u:hm (.) if it always blows from the same corner (.)
224 D 'hh when you are standing (.) As it were
225 D on the a[ching side ['hh that very well could be it yes (.)
226 P [hmm [hm
227 D I always think it's useless that air conditioning=
228 P =I th- I really hate it

Many instances of physicians' assessments in environments of type 3 also seem to do a job of "informalizing." In the instance quoted next, a strong negative assessment (in line 8), related to a central complaint, seems to be "a tease," which signals that the physician does take the complaint rather lightly, as have others before him (cf. line 11).

Excerpt 7

7 P ik heb me gebrand (.) zondag=
8 D =st[om
9 P [ik dacht heel ev- ja[inder d]aad (.) ik heb het
10 O [(huhhuhhuh)]
11 P eenenander aan (ge) moeten horen (uhHUHhuh) ('k wou) toch

maar even zie:n=
12 D =ja

7 P I've burned myself (.) sunday
8 D stu[pid
9 P [I thought for a mo- yes[(.) indee]d (.) I've had to
10 O [(huhhuhhuh)]
11 P listen to something-or-other (uhHUHhuh)(I would) see
for a moment yet
12 D yes

The next excerpt concerns a case of a patient who stumbles into the consulting room because of an ankle that should have healed by now but hasn't. Here the doctor's strong assessments of her condition seem to function to ward off her possible complaints about this lack of medical success.

Excerpt 8

1 D ja
2 P morgen [(uhm)
3 D [is het nog zo erg
4 P jaha
5 D o:h nee
6 P ja eerlijk
7 D ja
((voorstellen observant))
9 D nee u bent verdorie een invalide als je zo loopt zeg
10 P ja

1 D yes
2 P morning [(uhm)
3 D [is it still so bad
4 P yehes
5 D o:h no
6 P yes honestly
7 D yes
((introduction of observer))
9 D no you are an invalid damn it when you do walk like that
10 P yes

The two cases to be considered next stem from an encounter where a "biomedical" questioning is followed up with an episode during which the biographical background of the medical complaints is discussed (cf. ten Have 1989). In both instances quoted, the physician assesses parts of the patient's report with "difficult" (lines 102,216). This report concerns problems the patient experiences in her dealings with her 18-year-old son.

Excerpts 9

99 P ja en hij heeft dus om de haverklap geen werk
100 D (nja) 154

101 P dus nou ja dat vind ik dus wel eh: (3)
102 D moeilijk heh
103 P ja: vind ik wel
.....
212 P jaha maar ja nu weet-ie natuurlijk dat ik
213 P geweest ben (.) krijgt-ie te horen
214 D okee
215 P (huh)
216 D zeh- 't is erg moeilijk een dieetje (.) vie-
217 D vier weekjes (.) deze poeders

99 P yes and so he is often out of work
100 D (nyes)
101 P so well yes I think that so well uh (3)
102 D difficult huh
103 P yes: that's what I really think
.....
212 P yehes but now he knows naturally that I have
213 P been there (.) he will hear about that
214 D okay
215 P (huh)
216 D say- it's very difficult a little diet (.) fo-
217 D four little weeks (.) these powders

The first instance fits in a strategy in which the physician focuses on the mother's feelings in order to be able to discuss them later as "part of the problem" (ten Have 1989). In the second instance, the assessment is delayed, comes after "okay" and "say," and creates the impression of an inserted afterthought. The doctor has just suggested that she should keep in the background regarding details of her son's life, that she should avoid the impression that she is continually concerned about him. But now she mentions a complication to that, he will learn that she has been around at his place. By hastily inserting "it's very difficult" the physician accepts that it may be hard to follow his advice, while at the same time making it clear that he is not going to discuss these difficulties any further. His accepting assessment makes further detailing on her part superfluous. In fact, this assessment is part of a successful effort to initiate a closing of the encounter.

While the uses of assessments in the preceding cases seem to be tied to the specific occasions involved, some other instances are, in my view, examples of a more systematic application of assessments: in fact, they mostly come in series. In the following cases, and in others like them, such a string of assessments is used *vis-a-vis* children and seem to display a specific orientation to their identity *as* children. That is, uses of assessments here and elsewhere are part of a certain style of speaking to children that is not bound to a specific topic or occasion, but is chosen by some adults in any kind of talking to the children. Some aspects of this style are displayed in the transcripts

quoted in 6.10. In the first example, for instance, the doctor uses “sir” as an address term to a six-year-old boy, while the “pseudo-curse” in line 7 has the same “jolly” unseriousness. In the second example we see that the assessments are given to both medical and social aspects of the little girl, while in line 16 the mother displays an understanding of the doctor’s efforts as trying to engage the child in conversation.

Excerpt 10 a

5 D zo (.) vertel het es meneer
6 P ik heb steeds hoofdpijn
7 D wel (.) potverdorie hoe komt d[at
8 P [en als ik gaat hoesten
9 P danna (.) ko- gaat het hier pijn doen en op m’n hoofd
10 D ja[?
11 P [en als ik niest ook
12 D o:h (.) moet je veel hoesten Peter
13 P ja
14 D ja? (.) vervelend joh

5 D so (.) what’s up sir
6 P I have a headache all the time
7 D well (.) by Jingo how [come
8 P [and when I cough
9 P then-uh (.) co- it starts to hurt here and on my head
10 D ye[s?
11 P [and when I sneeze too
12 D oh (.) and do you have to cough a lot Peter
13 P yes
14 D yes? (.) that’s annoying lad

Excerpt 10 b

8 M Maja heb zo’n last van maaien
9 (0.7)
10 M h[eh?
11 D [da’s lastig (.) kriebelen ze Maja?
12 (0.4)
13 D rotdingen heh? heb je je diploma gehaald? ja heh?
14 (0.5)
15 D schitterend zeg
16 M nou kun je praten
17 P jha
((M=mother)

8 M Maja is very much troubled by maggots
9 (0.7)

10 M h[uh?
11 D [that's annoying (.) do they itch Maja?
12 (0.4)
13 D terrible things hm? did you get your diploma? yes huh?
14 (0.5)
15 D really splendid
16 M well can you talk
17 C yhes

So we may conclude that at least some physicians use a special "conversational" line of conduct when they deal with children, even when the main topic is being developed.

A similar "conversational" approach is sometimes discernable in the ways in which physicians deal with elderly patients. It may not be a mere coincidence that the patients who are "praised" for their "good behavior" in the next two examples are, to judge from their voices, elderly persons.

Excerpt 11 a

((after the patient has told his physician that he hasn't been taking any medicine recently))

135 D helemaal niks (.) [da's knap
136 P [( )
137 P jah jah
138 D heh?

135 D nothing at all (.) [well done
136 P [( )
137 P yes yes
138 D hey

Excerpt 11 b

28 P en ik ben op de weegschaal gaan staan en ik weeg nou
P a[chtennegentig
29 D [o:::h
30 D dat zijn goeie
31 P jah
32 D berichten

28 P and I went to stand on the scales and I now weight
ni[nety eight
29 D [o:::h
30 D that is good
31 P yes
32 D news

So, generally speaking, use of assessments in physicians' reactions to patients' answers, or other

kinds of telling, displays an orientation to that telling that treats it lightly, as part of small talk, of marginal topics, or it is part of a wider "conversational" approach taken especially with persons with a non-adult status.

"Oh" in physicians' third turn

As noted above, both Atkinson and Heritage maintain that "Oh" is one of the kinds of items that professionals rarely if ever use in their talk with clients, while it is quite commonly used in ordinary conversation. Heritage summarizes some of his findings in this latter area as follows:

> Through the use of the particle, informed, counterinformed, or questioning parties can assert that, whereas they were previously ignorant, misinformed or uninformed, they are now informed. Correspondingly, the informing, counterinforming, or answering party is reconfirmed as having been the informative, knowledgeable, or authoritative party in the exchange. By means of the particle, the alignment of the speakers in their sequence-specific roles is confirmed and validated. (1984 b:315)

So through the use of "Oh," a preceding item is labelled as having been informative, and, at the same time, the respective roles of the parties *visa-vis* the informing process is displayed. While patients quite often mark what their physicians tell them as news by the use of "Oh," doctors rarely do the same with patients' informings.[8]

Thus, I have been looking for exceptions to this general tendency in my corpus, locating 30 instances in which a physician receives a patient utterance with "Oh." Using the same typology of episodes as I did earlier, I observe that ten cases were used in environments that can be characterized as non-medical (small talk, etc.: type 1). Another ten cases were found to occur in episodes that, although more or less medical as to the topic under discussion, could be seen as relatively marginal in relation to the main medical agenda (type 2).

An example of the first type may be seen in the following extract which occurs at the beginning of the physical examination, often a moment when the physician starts some kind of small talk (cf. Frankel1983):

Excerpt 12

((at the start of the physical examination))

72 D (hmhm) (.) in welke bar werk je? in welke bar werk je?
73 P Paradiso op de Markt
74 D ohh (.) 'h als je eventjes dit uitdoet

72 D (hmhm) (.) which bar do you work in? which bar do you work in?
73 P Paradiso on the Market
74 D oh (.) 'h if you could take this off

An instance of the second type, below, is taken from an episode toward the end of a consultation in which the physician has asked the patient how her husband is doing. When she mentions a side-

effect of tablets the physician prescribed, he receipts this with “Oh” (line 3).

Excerpt 13

((near the end of the consultation, about patient’s husband))

1 P ja: en ‘t is niet zo erg maar nou die tabletten
2 P die: e:h krijgt-ie ‘t van aan z’n maag
3 D oh (.) da’s vervelend (.) moet ie ze met een beetje melk innemen
4 P beetje melk innemen
5 D ja (da’s beter)
6 P oh

1 P yes and it is not so bad but now those tablets
2 P tho:se uh his stomach hurts from them
3 D oh (.) that’s bad (.) he has to take them with a bit of milk
4 P take with a bit of milk
5 D yes (that’s better)
6 P oh

In relation to the collections from type 1, small-talk environments, and type 2, those marginal to the consultation, we might say that apparently physicians feel free to relax their professional habitus, since they are not being informed as a professional at these moments, at least not concerning the topic that is the major reason for the consultation. So we might conclude that the major discrepancy concerning the use of “Oh” is to be found in the type 3 data on the main business of the consultation. For this reason I will give most attention to this last set.

Before I do so, however, I will present a summary description of my findings concerning the type 1 and type 2 collections, as well as some suggestions from Heritage’s essay on the use of “Oh” in ordinary conversation, in relation to these findings. In most cases from these collections, the information receipted with “Oh” is of a kind to which the teller has a privileged access, for instance, biographical details. In many cases, also, the information involved contradicts apparently existing expectations, either as displayed by the recipient or as set up by previous information given by the teller. In some cases, “Oh” marks the moment at which the recipient understands a point the teller is trying to make, a moment of recognition.

These observations are mostly in line with the conclusions of Heritage, although the frequency with which Oh-receipted information has a biographical character may be specific for the types of situation considered in the present essay. An important point made in scattered remarks throughout Heritage’s paper is that an important difference exists between “Oh”s followed by inquiries, assessments, or formulations, on the one hand, and what Heritage calls “freestanding” “Oh”s, on the other. The last type is often used in such a way that a further elaboration of the topic under discussion is not invited, or is even discouraged. As he writes: “Whereas ‘oh’ may propose a change of state in response to an informing, it is entirely opaque as to the quality or character of the change of state proposedly undergone by its producer” (1984b:325). For this reason, informers may wait for an “unpacking” of this opaque message, and when none is coming conclude that the recipient is unwilling to give one. At the same time, an oh-receipt makes it clear that the informing has had some effect, and that further informing may be superfluous. Because of these suggestions, “Oh”

often has a sequence terminating effect. Heritage notes that freestanding "Oh"s are less common. In my data, I count one in the type 1 collection, four in the type 2, and three in the type 3. In the interest of space I will only discuss the latter examples.

In the ten cases that make up my type 3 collection, most of the general findings mentioned above are recognizably relevant. For example, biographical information is clearly involved in the next case,9 which also illustrates a process of counterinforming.

Excerpt 14[9] ((woman about her menopause))

270 D en tot die tijd heeft u g[ewoon
271 P [( )
272 ()
273 D regelmatig gemenstrueerd
274 ()
275 D ne[e?
276 P [nou niet regelma[tig,=
277 D [( )
278 D =oh 't was nooit regelm[atig
279 P [neu
280 (0.9)
281 P nee want ik ben (hier) 'n paar jaar terug hier
282 P ook wel 's voor geweest

270 D and until that time you [just
271 P [( )
272 ()
273 D menstruated regularly
274 ()
275 D n[o?
276 P [well not regular[ly
277 D [( )
278 D oh it was never regul[ar
279 P [no
280 (0.9)
281 P no because I was (here) a few years back
282 P for this too

The specific aspect on which the physician is informed is clearly displayed by him in his "oh it was never regular" (line 278). In this way the topic is kept open for further elaboration.

A similar display of understanding is given in the next case, 10 where the information concerns another kind of private information, the location of pain in the body.

Excerpt 15[10]

32 D en waar zit dat precies die kramp?=
33 P =hier is 't=

34 D =oh daar echt in die kuit ja

32 D and where is that cramp exactly?=
33 P it's here
34 D oh right there in that calf yes

In three other cases, "Oh" is also followed by a formulation of the produced understanding, although in these the formulations are not restricted to the "gist" of it, but also extend into an "upshot formulation" - to use the terminology developed by Heritage and Watson (1980). In all these cases an "oh" plus formulation displays confident recognition.

This leaves three remaining cases in which "Oh" is not followed by a formulation or something similar, and where the "Oh" is not part of some kind of "conversational" series, as in the cases quoted earlier. In the interests of space, I shall merely summarize my analyses of these three instances. These are "freestanding" occurrences of "Oh" where the "quality or character of the change of state" is left entirely "opaque" - as Heritage has formulated it - and where the physician initiates a topic shift or change soon afterwards. This condition has the effect of confronting the analyst, too, with an opaque action, allowing for only tentative interpretation at best. These oh-receipts occur in environments that can be seen as somehow awkward or delicate. In two of the three instances, the physicians seem to challenge the information provided, but when the patients confirm their previous stance, they subsequently acknowledge this with a freestanding "oh" and change topic soon thereafter. In this way they mark that they have noted the "opinions" expressed without offering any assessment of the information "noted" in this way.

These interpretations are far from definitive. The opaque and hinting quality of a freestanding "oh" and its tendency to contribute to a subsequent termination of the current sequence makes it difficult to provide any interpretation from further sequential development.

My analysis of the 30 instances of "Oh" produced by physicians during consultations has suggested two generally valuable interpretations. On the one hand, the use of "Oh" may be a part of, and contribute to, a "conversational" quality an episode in which it occurs may have. And, on the other, it may indicate that the information so receipted may be seen as one to which the informer has some kind of privileged access. The latter may concern biographical information as well as private opinions and feelings. In some special instances this last marking was tentatively interpreted as part of a challenging episode, occurring when a patient stuck to a contested report on her feelings. In this way the "Oh" seemed to give an extra mark of "this is your private opinion." While such a use is not uncommon in informal conversation, its rarity in professional reactions to clients' informings could add to its impact.

Asymmetry Reconsidered

I have suggested throughout this chapter that" asymmetry, " often conceived of as a given and constant feature of medical interaction, should instead be seen as an interaction ally achieved and varying aspect of the interactional stream produced by doctors and patients. It is not my intention to deny that phenomena that can be glossed as "asymmetries" are massively present in medical encounters. But I should like to stress that the choices participants have to act more or less in accord with institutional expectation, that is, in a more or less "asymmetrical" or "formal" way, can be exploited by them to create specific kinds of episodes and to achieve analyzable interactional effects. More research is needed to specify what has only been suggested in broad terms here. The strategy

pursued, to give specific attention to practices that depart from the routine, seems to be a promising one. The covert ways in which patients can try to influence the course of the consultation, alternatives to restrictive questioning, and alternatives to the third turn "uhuh," are all topics deserving more detailed exploration in the near future.

Consultations are sometimes almost like conversations. At other times they resemble interrogation. But mostly they are somewhere in between, zigzagging between the two poles in a way that is negotiated on a turn-by-turn basis by the participants themselves, whether they are Anglo-Saxons or Dutchmen.

Notes

Earlier versions of this paper were read at the Talk and Social Structure conference, and subsequently at the 11th World Congress of Sociology, Research Committee for Sociolinguistics, in New Delhi in August, 1986, and at the International Conference on Discourse in Institutions at the University of Dortmund in October 1986. It is here presented, with only minor corrections, as printed as chapter 6 in: Deirdre Boden & Don H. Zimmerman, eds. *Talk and social structure: studies in ethnomethodology and conversation analysis*. Cambridge: Polity Press: 138-63.

1 This debate could start with Atkinson's (1979) observations concerning efforts to "humanize" judicial proceedings by making them less "formal" and more like" conversations." He suggests that such efforts tend to ignore the inherent functionality of many institutional arrangements, such as the achievement of "shared attentiveness."

2 Except for fragment 15, all physicians quoted are male; patients, however, are both male and female. I have adapted my use of pronouns to this circumstance.

3 The data extracts are presented in a simplified form; the Dutch version will be followed by an English gloss, which is intended to capture the utterance as it was spoken, and not to provide fully colloquial English.

4 Harrie Mazeland pointed out to me that this can be done by using verbs like "to be" or"to have" for background items, as opposed to verbs like "to get" for the pressing complaints: compare, in Excerpt 3, lines 24-5 with lines 27 and 31.

5 This contrast between "respondents" and "informants" as locally constituted identities is currently being developed by Harrie Mazeland in a conversation analytic study of sociological research interviews.

6 This discussion, being restricted to "talk" as its topic, does not consider non-vocal devices. Christian Heath (1986) makes it clear that movements of the body can be used very effectively as "covert initiatives."

7 These findings are partially similar to what Frankel (1990) reports. He also mentions that most of his patient-initiated questions were put forward towards the end of the consultation, specifically at "unit boundaries," but -- contrary to my findings -- his examples display many dispreference markings, such as pauses, token acknowledgments and announcements, preceding the questions, even at those locations.

8 Just how rare this is cannot at the moment be specified. As far as Heritage knows it is very rare indeed in English language material. In eight complete consultations from my corpus, however, where patients used "Oh" 31 times, I have found that physicians produced 14 cases of "Oh:" My intuition is that this does not represent a "language" difference. "Oh" seems to function in a similar way in both languages. It may be an aspect of a more informal style practiced by Dutch physicians,

especially by general practitioners who know their patients for years.

9 This excerpt is a simplified version of a transcription made by van Mierlo and Driessen.

10 This excerpt is taken from a transcript made by Kaag, Koffieberg and Vreeburg.

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