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A DISCOURSE ANALYSIS OF TOPIC CO-SELECTION
IN MEDICAL INTERVIEWS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
Elaine Marie Litton-Hawes, B.A., M.A.

* * * * *

The Ohio State University
1976

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CHAPTER I

THE ORGANIZATION OF SOCIAL TALK AS RULE CONFORMING

Introduction

This study begins with the question how do two people—a doctor and patient—decide what to talk about during an interview. The focus is on how the topicality of talk influences the structure and function of medical interviews rather than on the nature of the content itself.

A second concern is with a method used to investigate the relation of language to social talk. This method is called discourse analysis. Because discourse analysis has only recently become an approach for the study of everyday talk, little is known about the procedures used for such analysis. This study will provide a critical evaluation of discourse analysis.

The problem

One function of language-use in conversations is to coordinate what is talked about (i.e., topic). When people talk, implicitly, they agree to talk about something. Selecting that something is a joint accomplishment. Stated another way, to converse people must
coordinate topics. The "co-selection of features for topic" (Schegloff, 1972) is a method people use to structure and control the development of their talk.

Individuals do think about the topics of medical interviews. In reporting their conversations, they describe what was talked about by saying "I had a hard time finding out why he (the patient) came to see me" or "I kept bringing up my backaches but she (the physician) didn't seem to be interested." These utterances are retrospective reports of interviews; they refer to "topic" as something which has been done.

People also seem to have expectations of what they will talk about before conversation begins. Thus, patients anticipate what topics they will have discussed when the interview is completed. They may even rehearse and make notes about topics they wish to discuss.

During conversations themselves, there is an awareness of what topics are appropriate. For example, in medical interviews it is considered inappropriate for a patient to talk seriously about the doctor's health. It may also be inappropriate for a patient to deny directly the relevance of a topic since presumably it is the doctor whose expertise allows him/her to judge relevance. If patients are uncertain of the appropriateness of a
topic, they may begin an utterance with, "this may be off the subject, but. . . ."

However, the fact that doctors and patients think about topics before, during, and after interviews does not mean that they are usually aware of how topics are constituted. This study deals with the how question. It provides an account of the methods doctors and patients use to "talk about things."

This first chapter focuses on two underlying theoretical issues: first, the social use of language as rule-conforming, and second, the organization of social talk as it relates to topic construction in interviews.

The Social Use of Language as Rule-Conforming

This study deals with the ways in which language is used rather than with its syntactic or semantic correctness. Certainly a knowledge or language production is required before people can do social talk. But a knowledge of syntax and semantics is a necessary, not a sufficient condition for persons to converse.

Thus, social scientists have begun to describe the organization of talk as social (as opposed to linguistic) action. To coordinate social talk people must produce socially meaningful utterances, combine those utterances into socially sensible sequences, and order the sequences socially, i.e., within a system of turns.
Scholars have identified these and other considerations as structural components with identifiable functions in the system of social talk. Explanations of how these structural components function are termed "rules." Rules are accounts of how the elements of social talk function interdependently.

Linguistic vs. social rules

A perspective used to discover these rules of language-use in social interaction is discourse analysis, where "discourse" is defined as the transcribed version of conversation. Discourse analysts have begun to identify formal components of spoken language. Whereas linguists have developed formal syntactic theories, discourse analysts study the social coordination that augments linguistic production. Although linguistic models have influenced the development of sociolinguistics, no clear evidence has related linguistic properties of speech to the social use of language (Turner, 1974).

One reason that linguistic models do not adequately explain the social use of language relates to the indexical nature of language itself. The indexing or naming of objects, events, or persons (with terms, such as, "he," "she," "this," "that," "it," "here," and "now") has almost infinite possibilities depending upon the occasion
of use. Yet native speakers seldom have problems selecting terms in talking. Auditors or readers make sense of language by using what Garfinkel and Sacks (1970) call "reparative practices." Reparative practices refer to the work auditors must do in deciding what terms refer to what objects or persons, in what occasion, in relation to what has been said previously, by whom, and so on.

Husserl referred to the indexical characteristic of expressions "whose sense cannot be understood by the auditor without knowing something about the biography and purposes of the speaker, the circumstances of the utterance, the previous course of talk, or the relationship (actual or potential) between the speaker and auditor" (Mohanty, 1964).

Percy (1972) illustrates the indexical characteristic of language in postulate form: "a sentence may mean anything it is used to mean" (p. 7). Thus, the indexical quality of language offers a wide range of variations for use in speech which are not accounted for in linguistic theory.

Chomsky (1957) also observed this dimension. "A grammar mirrors the behavior of the speaker who, on the basis of a finite and accidental experience with language, can produce . . . an indefinite number of new sentences" (p. 15).
So the question remains, how do speakers know what speech to use in the various and complex situations they find themselves? How do people make sense of others' speech? How is speech produced and heard—by members who use it—as an orderly phenomenon? If an inherent property of language is indexicality, how do members recognize and coordinate what they are talking about?

Rules as explanations

In an attempt to find explanations for language-use as a rational and orderly phenomenon, philosophers and social scientists have begun to study ordinary language as a rule-governed activity. Although rules may be initially derived from observations that certain behaviors regularly go together, rules are not simply descriptions of regularities. A rule is an attempt to demonstrate how one behavior (e.g., an utterance) follows another and how the members who perform that behavior understand it. Thus, rules seek to account for speech-using behaviors from the perspectives of the members who use them.

The perspective which derives rules as explanations of human action is a new paradigm for scientific study (Cushman & Whiting, 1972; Sanders, 1973; and Harré, 1974). Whereas, the more traditional approach to the study of social behavior is based on causal explanations, viewing man as a reactor or mediator of antecedent
conditions, the rule paradigm sees man as a conscious, planning, decision-making being who generates patterns of behavior. Sanders (1973) ties the concept of rule governed behavior to what he calls the grammatical paradigm. He contends that the grammatical paradigm is distinguished from the classical paradigm in that it presupposes that order in a given class of behaviors is a function of cognitive structure.

Toulmin (1974) states that it is easy to observe human conduct as sequential procedures conforming to rules and that "the part played by such rules in structuring intelligent behavior, are familiar circumstances of everyday experience which should lend themselves to direct investigation and analysis" (p. 187). He further outlines a taxonomy of seven types of rules to illustrate the complexity and variety of rules as accounts of human behavior. Toulmin's seven types are described along a continuum from non-rational naturally occurring regularities to consciously planned rational behavior. He argues, contrary to Sanders and Harré, that using rules as explanations does not rest on the assumption that human conduct is either conscious and rational or causally controlled, for no essential difference between 'rational conduct' and 'causal phenomena' exists. In fact, rules can be used to explain a variety of human actions which may have both rational and causal elements. The implication of Toulmin's argument is that rules are useful as
explanatory tools or, as Pepinsky (forthcoming) suggests of Toulmin's position, that rules exist because we (as scientists and social persons) impute them to things.

This study rests on the assumption that topic coordination in medical interviews can be understood as rule-conforming behavior. Such an assumption places the rules to be derived in the middle of Toulmin's continuum where rules are relevant to sequential behavior that has an arbitrary and conventional significance. Thus, the term "rule-conforming" behavior is used to imply a range of appropriate behaviors which are conventionally used, rather than "rule-governed" behavior which implies a more absolute definition of the rightness or wrongness of an activity.

Assuming a rule-explanation of topical coordination during medical interviews neither denies the significance of alternative explanations nor offers absolute proof that a rule paradigm is the most appropriate model for understanding language-use. The approach assumes that it is possible to understand topic formulation in interviews "as if" persons are conforming to rules. Stated another way, adopting a rule model necessitates a description of the methods parties used in coordinating what they talk about (or, how they talk about what they talk about) during the interview.
Characteristics of rules

A number of communication scholars, psychologists, sociologists, and psycholinguistics have emphasized the usefulness of analyzing the rule-conforming nature of social interaction (Austin, 1962; Grice, 1968; Rosenfield, 1968; Searle, 1972; Garfinkel, 1972; Labov, 1972a & 1972b; Turner, 1972; Cushman & Whiting, 1972; Sacks, 1972; Schegloff, 1972; Sanders, 1973; Speier, 1973; Harré, 1974; Toulmin, 1974; Nofsinger, 1975; Segal & Stacy, 1975; and Pepinsky, forthcoming). Although the sense in which rules have been defined and constituted varies, the following general conceptions of rule-conforming language-use apply in this study.

(1) Rules are formal descriptions of the operations performed by speakers in talking. Rules may be seen as a set of instructions for members of a speaking community. Thus, rules are often stated in an obligatory or imperative manner (Searle, 1972). For example, Sacks' (1968) rule for question-answer sequence is: "a proper question gets (or obligates) a proper answer." Segal and Stacy (1975) define a rule as "a procedure applied to a variable" (p. 543). The first part of their definition relates to the procedural characteristic of rules. The second part of the definition specifies the classification of a "variable."

(2) The second characteristic of rules is that they perform a categorizing function. They define or account for what constitutes a speech act. Labov (1972a) emphasizes that rules of discourse must keep what is said distinct from what is done. Linguistically, "are you coming to the clinic next week" is defined as a question. But in discourse it may function as a request for confirmation. Segal and Stacy (1975) emphasize that an important aspect of categorizing is the definition of the act being performed. The rule-procedure is organized around the act performed. Segal and Stacy (1975) stipulate that the act is a functional unit rather than a structural one 'because the same behavior patterns (or speech) and contexts serve different functions at different times' (p. 546).

(3) Because the same speech patterns serve different functions at different times, rules must specify the conditions under which the categorized act operates. The conditions are usually termed "presuppositions." The presuppositions usually specify something about the speakers who are conforming to the rules and the conditions under which the rules are used. The presuppositions deal with the interpretation of action from the point of view of the actors. For example, Labov's (1972a) rule for one form of question-answer sequence includes the following presuppositions.
Given two parties in a conversation, A and B, we can distinguish as 'A-events' the things that A knows about but B does not; as 'B-events' the things which B knows but A does not; and as 'AB-events' knowledge which is shared equally by A and B. The rule then states:

If A makes a statement about a B-event, it is heard as a request for confirmation (p. 301).

Thus, a necessary presupposition for Labov's simple question-answer rule specifies that the users have individual and shared knowledge. Similarly, Searle (1972) states that a presupposition for a promise is the undertaking by the speaker of an obligation to perform a certain act.

The presuppositions for rules assist analysts in understanding how utterances function in discourse. When rules do not apply, it is possible to look to the preconditions and identify one or more which have not been met. Thus, a speaker may "use" a rule with the intention that the listener will impute that intent to the speaker.

When the listener does not conform to the rule in use, she/he may call into question one or more presuppositions or be "accused" of not conforming to the rules. This observation indicates that rules of discourse are interpreted arbitrarily. Speakers may differ in their assumptions about presuppositions and may subsequently interpret each other's speech differently.
The above examples are not comprehensive explanations of rules, but they do illustrate three central characteristics. It has been shown that (1) rules are sets of instructions which formally account for or describe the procedures speakers use in conversing. (2) Rules categorize acts performed with words. The categorizing refers to the identification of a speech act, such as, a confirmation, a request, or a question. (3) A set of presuppositions stipulates relations of the users and the conditions under which the rules operate.

A description of some of the rules which seem to govern the use of language in medical interviews is a necessary beginning if we are to better understand how people coordinate what they talk about in this typified situation. Because medical interviews are assumed to include a large number of rule-conforming speech behaviors, the following section describes what is presently understood about the organization of social talk as it relates to topical construction.

The Organization of Social Talk

Conceptual perspective

The perspective which informs both this study and previous analyses of social talk is grounded in the constitutive phenomenology of everyday life described
by Schutz (1967). Because ethnomethodology springs directly from Schutz's work, assumptions of ethnomethodology as developed by Garfinkel (1972) also influence the conceptual framework. Three basic assumptions are of particular importance.

First, the social world is assumed to be intersubjective; not a fact but an improvisational creation continually evolving through communication with others (Hawes, 1973). Through communication people make sense of their worlds. The "created" worlds of individuals are not viewed as unique but as connecting with sets of unquestioned previous experience. The connecting of experience enables persons to organize their actions and view their worlds as orderly.

Second, it is assumed that people coordinate their actions. The activity of communicating requires a kind of orderly coordination. To accomplish social activity, such, as conversing, negotiating, or interviewing, people must behave in concert with one another. In order to accomplish coordinated activity, people interpret each other's actions subjectively. The subjective interpretation of others is not a defective irrational (as opposed to objective rational) approach but, rather, a common-sense or reasonable course of action based on the concerted actions of others. When persons breach
the common-sense order of events, their behavior is noticed as inappropriate or atypical.

Third, although people do not "know" the subjective interpretation of others, it is assumed that they behave "as if" they share "various tacit understandings" (Garfinkel, 1972). When persons engage in talk, they bring with them sets of past experiences which assist them in interpreting the ongoing event. These tacitly held understandings are enacted through speech. Through speech conversants create what they assume to be shared understanding. The "as if" assumption of shared understanding points to the fact that persons expect themselves and members of the same speech community to engage in a commonly shared scheme of communication. The scheme of communication encompasses this tacit understanding and is enacted through a system of signals and coding rules (Garfinkel, 1972; Patton & Fuhriman, 1975).

The purposefulness and orderliness of human action directs the social scientist to search for explanations of how social actors structure their talk and how that structuring functions to regulate interaction. The following section describes some of the characteristics of the structure and function of social talk.
Organizational characteristics of talk

To understand the perspective being employed let us examine the way scholars have described the organization of social talk. Their ideas will provide a conceptual base from which to proceed. Three areas of study which have received attention are (1) the organization of utterance units, (2) the sequencing of utterances, and (3) the structure of turn-taking.

Utterance units. Talk is built through a series of utterances. Although definitions of "utterance" are not uniform, most analysts use the utterance as a basic structural unit. Speier (1973) argues that utterances are to conversation as sentences are to language. He assumes that utterances are formed in accord with a set of conversational rules just as sentences are formed according to a set of grammatical rules.

Although definitions of utterance units differ, for the purposes of this study, an utterance will be generally equated with a sentence, clause, phrase, or lexical item. The utterance, rather than the sentence, becomes the basic unit in order to include the numerous abbreviated and elliptical forms of responses available to speakers, such as, "uhuh" and "right" which do not satisfy the grammatical criteria of "sentence."
Four features of utterance units are of interest here. First, in producing utterances, speakers project a sense of planfulness. An utterance projects a beginning and a particular construction or order which suggests to the listener how the utterance will be completed. For example, utterances beginning with wh-words project the possibility of a question type utterance to follow (Sacks, Schegloff, and Jefferson, 1974, note 32). As speakers extend utterances, the extensions modify the directions of the utterances. There are also common beginnings which do not reveal much about the construction to follow. For example, Sacks, et al. (1974) observe that appositional words, (e.g., "well," "but," "now," and so on) do not reveal much about the construction of an utterance and, thus, do not require a speaker to have a plan in hand when beginning an utterance. While the order of utterance units is constrained by syntactic features, it is also influenced by the social situation in which utterances are produced.

Thus, a second feature of utterance units is that their meaning varies with the interactional occasion in which they are used. For example, the utterance "my husband is oblivious to time" when stated to a doctor may be heard as an explanation for a patient's difficulty in maintaining regular eating patterns. When
spoken to a friend of the speaker, it may be heard as a complaint about a spouse's lateness.

This example also illustrates a third feature of utterances. In producing utterances, speakers do more than create linguistic units, they perform "speech acts." Searle (1972) suggests that, although sentences can contain the same or similar content (and in the above example, the same grammatical structure) in the utterance of a sentence, a speaker expresses a proposition which may be heard as a question, a promise, an assertion, a command, a complaint, or other "speech act." The concept of speech acts has influenced a number of excellent studies of rule-conforming language use, including Searle's (1972) work on promising, Labov's (1972b) investigation of rules for ritual insults, Jefferson's (1972) work on side sequences, and Nofsinger's (1975) analysis of the demand ticket.

Related to the idea that utterances constitute identifiable rule-conforming speech acts is a fourth feature of utterance units. Utterances introduce topics. Thus, Schegloff (1968) describes topic as "activity being accomplished in utterances" and demonstrates that in topic interpretation, hearers must perform the operations of categorizing and analyzing to find the relevant respects in which utterances are used. Later, Schegloff (1972) suggests that it is more useful to conceptualize
the study of "talk on a topic" as "co-selection of features for topic" (p. 78). He does this to emphasize that topic in social talk is a mutual accomplishment. In connecting their utterances, persons "constitute" a topic. This connecting activity indicates that co-selection of topic operates through a set of sequencing rules. Sequencing will be discussed in the following section.

Four features of utterances are that (1) they may project a sense of planfulness, (2) their meaning varies with the interactional occasion in which they are produced, (2) they constitute speech acts, and (4) they introduce topics which are influenced by other speakers.

This fourth feature indicates that the production of an utterance is not an independent action. Utterances are produced and interpreted (by hearers and/or social scientists) within a stream of other utterances. Thus, a second area of study of the organization of social talk deals with the sequencing of utterances.

**Sequential organization.** Both speakers' turns and utterances within turns occur in serial order or sequence. The importance of the sequential organization of talk is first derived from the observation that social talk is governed by time—both clock time and perceived time. It is the notion of perceived time that makes sequence important. A party-by-part order is experienced
by persons as they hear each other in relation to their own speech. Thus, persons build social talk by connecting their utterances to those they hear.

The connecting of utterances by speakers includes the activities of hearing, interpretation, and production of a subsequent utterance. Although the relationship of these activities is not clearly understood, Labov (1972a) suggests that there are several hierarchical levels of sequencing activity which relate rules of interpretation to the production of utterances. At least two levels of sequencing have been identified and are described as rule conforming: (1) utterance pair sequencing and (2) topical sequencing.

Sequencing rules can be observed between utterances that regularly go together: paired greetings; summons/answers; correction-invitation devices/confirmation or refusal; demand tickets/acceptance or refusal; and questions/answers. These are referred to as utterance pairs. Although many utterance pairs can occur within an interview, question/answer pairs are the predominant type.

Schegloff and Sacks (1974) state that utterance pairs have the following characteristics: (1) two utterance length, (2) adjacent positioning of component utterances, (3) different speakers producing each utterance, (4) partitioning into first and second pair parts, (5) discriminative relations of first and second pair
parts. An utterance pair is produced when one speaker states a first pair part immediately followed by a different speaker stating the second pair part.

The fifth characteristic of discriminative relations indicates that the first part of an utterance pair is relative to the production of the second pair part. This discriminative relation of utterance pairs indicates that a first pair part may be said to obligate a second speaker to a second pair part. Thus, one pragmatic use of an utterance pair noted by Schegloff and Sacks (1974) is that, if produced correctly, it is a method one speaker uses for partially controlling the next speaker's utterance.

Although utterance pairs may have other functions, such as, ritual performances, they do serve as an organizing feature of social talk and can be described as rule conforming. Schegloff and Sacks (1974) describe the basic rule of utterance pair operation as follows:

... given the recognizable production of a first pair part, on its completion its speaker should stop and a next speaker should start and produce a second pair part from the pair type the first is recognizably a member of (p. 239).

Of particular interest in interviews in general, and medical interviews in particular, is the question/answer utterance pair. Sacks' (1968) rule for question/answer pairs states that a proper question gets a proper
answer. The rule can also be stated, a proper question obligates a proper answer to emphasize the fact that it is difficult for a second speaker not to answer. Even the reply, "I refuse to answer that," is heard as an answer.

A further condition of the question/answer pair described by Sacks stipulates that the questioner reserves the right to speak again after the second speaker has answered. Thus, a second interchange is implicated by the first. If the questioner begins the second interchange with a question, a chaining sequence results: QAQAQA.

An alternative to the chaining rule occurs when a question is answered with a question. By positioning a question in the place reserved for an answer, a speaker may be responsive to the original question and use the second question as a tactic to find out what the speaker wants. Speier (1973) argues that this tactic is quite logical inasmuch as the second speaker is being obligated to answer. By answering a question with a question, a speaker can regain control and put off the answer to a later turn. Now the chaining pattern is altered and the control is reversed to the second speaker. If this happens continually, where the answerer continues to break the chain (postponing his/her answer to a second
interact), he/she may be accused of strategically evasive behavior or of not conforming to the rules.

The strong obligatory feature of the question/answer rule and the potential chaining pattern gives considerable control over the interaction to the initial questioner. Thus, the question/answer pattern which predominates in medical interviews gives control to the doctors. The relation of the doctors' control to topic activity is an important concern for this study.

Topical sequencing is observed in the connecting or tying of topics. The notion of topical tying assumes that in any normal interaction speakers must keep track of the progress of topics to maintain some kind of continuity.

Grice (1968) has proposed that social talk is governed by a cooperative principle.

Make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk-exchange in which you are engaged (p. 7).

Grice defines the cooperative principle in terms of four maxims. Of particular interest is Grice's maxim of relevance. Grice refers to relevance as the coordination of subjects of a conversation and stipulates that a speaker's contribution should be appropriate to the immediate needs of each stage of the exchange. Grice admits, however,
that real as opposed to apparent violations of the relevance maxim are difficult to locate.

Sacks (1968) observes that a general method of coordinating topics is in connecting concepts (objects, persons, activities) of the same class. For example, the concept of "family" introduced by a first speaker may be tied to "mother" or "wife" by a second speaker. Sacks' general rule for describing topical sequencing is

A given part of an utterance can be analyzed to find that it has some (actually many) class statuses. Having found some class status for that given item, like cigar or cigarettes, one may in the next utterance present such an utterance that has a term that stands in co-class membership with a term used in the last. 'A' talks about cigars, 'B' talks about pipes (p. 8).

Sacks states; however, that co-class membership is not a very discriminative way to study topic talk, inasmuch as examples of items which do not fit a natural class can easily be found. Thus, some items are used sequentially and become members of a class for a topic. For example, Sacks illustrates that "son" and "dog," not naturally members of a class, can become members for the topic of "renting an apartment."

From another perspective, control over topical talk can be related to turn order. A first speaker in face-to-face interaction usually has the choice of first topic selection. Schegloff (1968) observes that in the
structure of telephone calls, the caller may select the first topic for talk. Similarly, Turner (1974) suggests that in face-to-face conversation the initial greeter has a right to talk again after the greeting is returned. The greater becomes a first speaker with rights to topic selection. Turner's observation may not apply in situations where one party has requested the meeting. For example, in medical interviews the doctor may expect the patient to introduce the first topic. In spontaneous meetings, however, Turner's suggestion may be accurate.

A special case of Turner's observation is illustrated when an initial greeter uses a demand ticket. Nofsinger (1975) demonstrates that one of the functions of a demand ticket is to give the speaker's role to the person who utters it and also obligates the acceptor to listen (p. 3). Using a demand ticket then obligates the first speaker to introduce the first topic while the second speaker selects a response which ties into that topic in some way. Another form of a demand ticket not only obligates the attention of a listener but restricts the topic immediately as in the example, "Guess what happened in the faculty meeting."

The sequential organization of utterance pairs and topic tying and selection point to a more general feature of the organization of social talk—that is, talk is structured through a system of turns. Thus, while
utterance pairing and topical tying imply a turn system, turn organization influences all forms of social talk. It is important to consider turn-taking as a central phenomenon in its own right.

**Turn-taking organization.** The most comprehensive examination of turn-taking has been done by Sacks, Schegloff, and Jefferson (1974). Their observations of turn-taking indicate a number of ways in which this system functions to partially control sequences of utterances. In two-party talk, speakers are assured a number of turns and have some freedom in fitting many utterances into one turn. Each utterance may constitute a potential topic. Where pressure for minimization of turns occurs, speakers must construct utterances so that their essential formation is intact early. Thus, speakers may need to introduce topics early or risk losing the turn before a topic has been completely formulated.

Sacks, et al. (1974) argue that utterances in a turn regularly display a three-part structure; one which relates to a prior turn; one involved with the present turn; and one which points to a succeeding turn. Thus, a turn connects to a turn on either side. Sacks' analysis indicates that the turn-taking system exerts pressure for these systematic potential turn-parts to be accomplished before the completion of a turn. It is
possible that the three-part structure of utterance units in a turn may influence how topics are formulated.

These observations of turn-taking suggest that there is an intrinsic motivation for listening in social talk. This is particularly apparent in two-party talk where the listener is always the next speaker. The nonspeaker in interviews is obligated to listen in order to carry out turn transfer properly. To appropriately connect her/his next turn a speaker in two-party talk must decide what type of utterance is being employed (e.g., greeting, question, joke, and so on) and what the topic of the utterance is.

An important feature of the turn-taking system, Sacks et al. argue, is a central resource for the student of social talk. In a turn a speaker, A, by addressing a question to a listener, B, limits the possible responses which can follow in the next turn. B's utterance will then display understanding of A's utterance as a 'question.' This interactional character of social talk becomes a central resource for the analysis of topic construction.

Since it is the parties' understandings of prior turn's talk that is relevant to their construction of next turns, it is THEIR understandings that are wanted for analysis. The display of those understandings in the talk of subsequent turns affords both a resource for the analysis of prior turns and a proof procedure for professional
analyses of prior turns—resources intrinsic to the data themselves (Sacks, et al., 1974, p. 729).

The above observations describe very general characteristics of the organization of social talk which apply in a wide variety of interactional occasions including interviews. Speier (1973) speculates that an interview situation may be a special sort of occasion in that "the position of the interviewer as elicitor of information and opinions may build into the talk closely knitting procedures based on the offering of leading questions . . . and the willingness to accept them by the recipient" (p. 107). Speier's speculation seems reasonable given the tightly knit feature of question/answer sequences which characterizes interviews in general and medical interviews in specific. Thus, I assume that question/answer sequences are powerful ways of controlling topic co-selection. Since a second speaker is obligated to answer and speaking rights are returned to the first speaker following the answer, physicians, as questioners, have a great deal of control over topical talk.

In light of the physician's control, questions which focus on how topics are raised, preserved, shifted, and closed in medical interviews direct the concern of this study. A description of the methods doctors and patients use in co-selecting topics will hopefully add to what is
presently understood about the social organization of talk.

Summary

The study of language as social activity has only recently received systematic attention. Scholars interested in structural and functional elements of social talk have adopted the perspective that the organization of social talk can be understood as rule-conforming behavior. The study of topic co-selection in medical interviews can, thus, be examined from such a perspective.

Previous studies have examined general characteristics of the organization of social talk. They suggest that utterance units are basic elements of social talk which are connected through three types of sequencing—utterance pair sequencing, topical sequencing, and turn sequencing. Chapter II discusses the method used to investigate topic sequencing in medical interviews. Chapter III reports the results of the analysis. Chapter IV discusses conclusions derived from the results and evaluates problems associated with discourse analysis methods. Chapter V summarizes the study and suggests implications for future research.
REFERENCES


CHAPTER II

PROBLEMS ASSOCIATED WITH DISCOURSE ANALYSIS
AND METHODS FOR THE STUDY

Introduction

The first goal of this study is to provide an account of rules for co-selection of topic in doctor-patient interviews. A second goal is to evaluate discourse analysis as a method for studying social talk. This chapter will (1) discuss several problems associated with discourse analysis procedures, (2) suggest criteria which may be used to evaluate studies using discourse analysis, and (3) provide a retrospective account of the procedures used in this study.

Problems Associated with Discourse Analysis Procedures

There are at least three problems which make discourse analysis difficult for students of communicative behavior. The first is that published research using discourse analysis includes relatively little discussion of procedures used for deriving results. The studies reviewed in Chapter I are not written in a conventional empirical form. Rather, they present a formal description, initially based on the intuitive notions of the researcher.
with supporting evidence from selected transcripts. The use of intuitive judgments is based on the assumption that the researcher possesses the cultural or communicative competence necessary to interpret the actions of members of the same language community (Nofsinger, 1973, pp. 6-14). For example, Labov (1970) states that "the first challenge in discourse analysis is to account for our intuitions (as confirmed by the response of the participants)," (p. 300). Similarly, Sacks (1972) introduces several rules of conversational sequencing with the phrase "the facts are so obvious that you can check them out easily for yourself," (p. 229).

For discourse analysts, talk is both the subject of and resource for study. While the researcher cannot eliminate her/his cultural knowledge of the subject matter, she/he must create an analytical account which is not unique only to her/his own intuition. Turner argues that problem is an unavoidable reality.

The sociologist inevitably trades on his member's knowledge in recognizing the activities that participants to interactions are engaged in; . . . . This is not to claim that members are infallible or that there is perfect agreement in recognizing any and every instance; it is only to claim that no resolution of the problematic cases can be effected by resorting to procedures that are supposedly uncontaminated by members' knowledge (pp. 204-205).
The importance of intuition as a foundation for knowledge derived from a phenomenological perspective is well recognized (Bruyn, 1966, pp. 278-279). Nevertheless, an intuitive approach does not lend itself well to the articulation of orderly procedures in advance of investigation. Thus, while it is understandable that researchers may not know how they will proceed in advance of the precedent, it is unfortunate that they have written so little about procedures in retrospect.

A second related problem for students of discourse analysis is the lack of discussion by discourse analysts concerning criteria for judging the validity and reliability of their work. Labov (1970) indicates that discourse analysis is in a primitive stage of development analogous to the earliest developments of linguistics in syntax and morphology (p. 304). Similarly, Speier (1973) terms discourse analysis "a natural history approach" similar to simple biological models of investigation in ecology and ethology. Speier offers useful advice for observing and gathering data, but suggests only very general guidelines for analysis and related criteria.

A third problem confronting discourse analysts relates to the means by which findings are made evidential. Like any new form of research, discourse analysts are asked to justify the way in which their data support their claims or conclusions. Perhaps this is because
the published form of their results is unlike more
traditional types of research methodologies, such as,
experimental research. Although discourse analysis is
qualitative research and experimental studies are quan-
titative, the problems of evidentiality for the two
types are not as different as they might seem. At the
risk of oversimplification, let us make some comparisons.

The quantitative researcher traditionally uses
statistics as a measure of central tendency to summa-
ize and interpret the data. The discourse analyst uses
rules to describe formally a central tendency of the
data.

While the quantitative researcher often infers a
causal (or correlational) relationship between an inde-
dendent and dependent variable in order to discover laws
of human behavior, the discourse analyst like the parti-
cipant observer typically rejects causal explanations in
favor of more sensitive intentional (purposive) explana-
tions.

The problem of evidentiality for a quantitative
researcher is tied to the method of operationalizing
and measuring concepts. More specifically, the question
of evidentiality asks if the observations and the statis-
tics used to summarize those observations—thereby
generating data—are suitable. Stated more traditionally,
does the way in which the observations were made satisfy the assumptions of the statistic?

For the qualitative researcher the question of evidentiality is, are the observations made and the rules to which they are said to conform, suitable. Stated more traditionally, do the observations satisfy not only the presuppositions for the rules, but the logical entailments of the rules. In both qualitative and quantitative cases, the problem of evidentiality is, in essence, a question of suitability. Criteria for determining the suitability of rules resulting from discourse analysis are discussed in the next section.

For the discourse analyst the problem of evidentiality is related to the clarity of detail generated in the explication of concepts. The discourse analyst uses data both to derive rules and to support the claims made by the rules. The quality of evidence then relates not to the number of examples but to the ability of the examples to illustrate the power of the rules in explaining different situations.

In essence, the problem of evidentiality for the discourse analyst is rhetorical. The question of evidentiality asks what makes an argument persuasive to a particular audience. The truth of the matter is, the discourse analyst thinks and thinks about a large sample of utterances until she/he acquires a convincing
explanation for the organization of the utterances. The explanation is convincing to the analyst because she/he has exhausted all other options. In an attempt to cope with the conventions of the social science community, the analyst uses the native competence argument to indicate the conclusions constitute more than private knowledge. Thus, a test of the evidence is similar to a test for reliability—asking if others would arrive at the same conclusions. The real test of evidentiality, then, is whether the reader recognizes the validity of the explanation and agrees. It is because of the absence of certain other rhetorical conventions in the social sciences that the question of evidentiality seems so difficult when discourse analysis is examined. While there are many rhetorical conventions available to the quantitative researcher (e.g., the use of p-values in statistics), there are few established in discourse analysis.

Because the criteria for procedures affect the suitability of evidence, the following section proposes criteria for discourse analysis methods. The final section of this chapter addresses the problem of procedures by describing the steps used in this study.
Criteria for Discourse Analysis Methods

The following criteria are proposed for evaluating discourse analysis methods. Because a theory of social talk has not been developed, a goal of the discourse analyst is to generate rules which may be subsequently read as elements of a theory. Discourse analysis, therefore, is similar to a general method of grounded theory. Glaser and Straus (1967) define grounded theory as a process of constant comparison of conceptual categories and data in which hypotheses are continually tested and modified. The following criteria are consistent with the grounded theory approach. The criteria for observing and for interpreting data are listed separately.

Criteria for making observations

Two criteria for collecting data are proposed. First, the researcher should specify the conditions under which the data are obtained. Whether there is an essential difference in social talk recorded for the purposes of a researcher and talk conducted only for the purposes of the speakers involved is not known. Therefore, the researcher should indicate as precisely as possible how the data were collected. Although frequently overlooked, this criterion is necessary if subsequent researchers are to be able to replicate the study. For example, Sacks, Schegloff, and Jefferson
(1974) make the following statement about their observations for an analysis of turning taking organization:

For the last half dozen years we have been engaged in research, using tape recordings of natural conversation, that has been increasingly directed to extracting, characterizing, and describing the interrelationships of the various types of sequential organization operative in conversation (p. 698).

The statement does not describe how the conversations were recorded, how many speakers were present, what the researchers mean by "natural" conversations, nor how conditions under which the recordings were made varied. Presumably, discourse analysts require data from a wide variety of settings. If this is the case, they need to specify how the data were obtained.

Second, the researcher should provide relevant information about the nature of the sample. Glaser and Strauss (1967) indicate that sample size is not as critical in theory generation as in theory verification. However, the type of sample used is critical to the observations. Inasmuch as some rules may be situationally specific, the researcher needs to specify the relationships of the participants, their apparent understanding of the occasion for talk, and why the occasion is suited to the research questions. This information helps other researchers assume a similar perspective and evaluate the insights of the interpretation. The
presuppositions for rules provide, in part, such a perspective.

Criteria for interpretation of data

With the notion in mind that rules are accounts of how the elements of social talk function interdependently, seven criteria can be specified to guide the interpreting of data.

First, the discourse analyst must demonstrate that the rules generated are consistent with the data. Glaser and Strauss (1967) refer to this criterion as sensitizing capability, "[concepts or rules should] yield a 'meaningful' picture, abetted by apt illustrations that enable one to grasp the reference in terms of one's own experience" (p. 38). The sensitizing capacity of examples of discourse usually illustrate situations of everyday talk—talk very familiar to other social scientists. Discourse analysis can use counter examples to illustrate the power of the rules or provide reasonable evidence that counter cases do not occur. The sensitizing capacity functions by showing the consequences of violating rules. In the detailed explication of the rules, the discourse analyst demonstrates their ability to account for the complex features of talk.

A second criterion for discourse analysis is that the rules must be internally coherent. Rules must
complement and elaborate other rules relating to the same phenomenon. Obviously, if one rule contradicts another, neither is, by definition, a rule. Rules may be contingently relevant, that is, one rule may be conformed to only when a higher level rule is operative. Unless the relationship of the rules to one another is clear, their internal coherence is not apparent.

Third, the rules of the discourse analyst should demonstrate a capacity to explain related theory. As the literature of discourse analysis grows, this criterion should become increasingly important. For example, the rules and related observations of turn-taking should add insights for theory in small group and organizational decision making. Rules for topical talk may help to explain physician-patient relationships. Ultimately a large body of discourse rules may become elements for a phenomenological theory of interpersonal communication. While the rules may help to explain related theory, they should not evolve from pre-existing theory. Although the discourse analysis literature may offer ready explanations for the data, similarities and convergences with the literature can be established after the analytic core of concepts has emerged.

The fourth criterion relates to the predictive quality of the rules. If the rules account for the data, they will help to account for and anticipate similar behaviors under similar circumstances.
The fifth criterion stipulates that the discourse analyst must maintain a balance between subjective and objective interpretation. Guarding against overly idiosyncratic subjectivity, the analyst must not attribute meanings which cannot be accounted for within the context of the sequence of utterances being examined. Recall Sacks' et al. (1974) observation that a central methodologic resource for the analysis of social talk is that speakers display their understanding of prior turns in subsequent turns (see Chapter I, p. 26). Thus, the evidence for observations must grow from the context of the data while preserving the point of view of the participants.

Objectivity in the fifth criterion is fulfilled to the extent that the reporting of data allows other qualified people to observe and verify the interpretation. A more complete discussion of objectivity and subjectivity in phenomenological research is found in Bruyn (1966).

The sixth criterion proposed is that the discourse analyst must use clarity and detail to allow for verification of the findings. In addition to criteria for observation of the data, detailed explication of examples allows other social scientists to interrogate the data.

A standard of the heuristic value, the final criterion, is traditionally applied to research. The heuristic
criterion is of particular importance in the aim of discourse analysis to generate elements for theory. The richness of explanations and their ability to stimulate further study are important tests of the value of discourse analysis research.

The above criteria are proposed as standards for judging results and as measures of the suitability of evidence in discourse analysis.

The first section of this chapter discussed the problem of procedures. When accepted methods have not been established, a researcher must proceed in a fashion that seems reasonable with the expectation that some attempts will not be fruitful. Although most researchers do not report methods in retrospect, the following section is included for two reasons. First, because a report of the conditions of observation are consistent with the criteria I have proposed. Second, because a retrospective account of actual procedures may be useful to others who want to use discourse analysis.

Methods for the Study of Topical Talk

Recording

The data for this study were derived from videotapes and transcriptions of 16 initial doctor-patient interviews recorded at the University of Minnesota Medical School. Two of the interviews were taped in the Student
Health Center Outpatient Clinic. The remaining 14 were taped in the University Hospital with patients who had been referred for diagnosis and testing. In all interviews the patients initiated the contact with medical personnel, that is, interviews would have taken place whether or not they had been videotaped. All patients and physicians freely consented to have the interviews recorded. None of the participants had met before the interviews took place. Subjects included 10 male patients, six female patients, and five male doctors. Each doctor recorded from two to four interviews. Patients ranged in ages from 21 to 55, although one patient was 73 years. Each patient was interviewed only one time.

Transcription

Although transcripts of the recordings were already available, they did not include detailed notation of the length of pauses, overlaps, and features of intonation. The transcripts were compared with the tapes for further notation. The videotapes were used throughout the analysis stage to check for accuracy of notation and wording.

Procedure

Initially, four transcripts were used for exploratory inspection. During repeated readings, notes were made in the margins to identify topic shifts and subject
content. Concurrently speculative observations were recorded in a journal. After repeated readings of the transcripts, procedural steps which seemed reasonable based on the procedures for grounded theory were outlined. The steps are listed below:

1. Complete transcript notation (including overlaps, pauses, etc.)
3. List assumptions for the phenomenon
4. List and define categories integrating #2 and #3 above
5. Refine categories according to step #4
6. Test categories by listing utterances from a new transcript on separate cards and sorting the cards into the categories in step #5
7. Select categories for focus
8. Generate maxims for use of categories in #7
9. Set up rule correlations according to maxims in #8
10. Test rules in step #9 by comparing with other transcripts
11. Modify rules
12. Refine rules and select examples from transcripts for illustrating the rules

Originally, I had planned to define topical categories for each utterance in the four transcripts (steps #2-5). After recording utterances separately on cards, I attempted to sort them into discrete categories (step
This became difficult because the separate utterances were too intimately tied to the context and sequence of each interview. As a result, I stopped trying to devise topical categories since my initial attempts failed to identify discrete and easily definable categories.

Thus, I returned to the transcripts, selecting one with which I was unfamiliar. Using a blank sheet of paper to cover the utterances in each turn, I attempted to predict subsequent utterances of doctors and patients. In this way I attempted to take the role of doctor and patient to determine if my own language competence would enable me to predict topical patterns. This technique enabled me to view the utterances in the transcripts from different perspectives.

During this period, I continued to write observations in the journal. I found that my ability to predict the subjects of subsequent turns was generally accurate following doctors' question utterances. This observation seemed trivial, however, at the time. I returned to the transcripts to look for places where the subjects of questions did not allow a prediction of subjects in the next turn and found very few places where questions did not appear to allow the prediction of subjects in answers.

While studying my journal notes and re-reading some of the literature, I resolved to become more systematic
by looking for patterns of sequencing. To visualize
the sequencing I xeroxed several transcripts and pro-
ceeded to cut them up into turns. This allowed me visually
to separate sequences of talk relating to the same
subject. Preliminary attempts to diagram topic struc-
ture, however, did not seem useful, for the cut-up
transcripts showed little consistency across interviews
in the flow and break of topical sequences.

At this point I concluded that I had traveled
through many blind alleys and returned to my journal
to attempt to organize all that I felt confident about
in relation to topical talk in the interviews. It
should be apparent that steps #2-7 were only partially
satisfactory. Step #8, the generation of maxims, was
the result of the organization of journal notes. The
maxims revealed principles to which the speakers seemed
to conform.

After listing the maxims, I returned to the trans-
scripts, this time using all 16 in the sample, to look
for evidence which seemed to contradict the maxim. For
example, one maxim indicated that doctors preserve
topics by using a verbalization ("uhuh," "yes," "I
see"). After reviewing the transcripts and videotapes,
I found unsatisfactory evidence to support this maxim
and I eliminated it from my list. Several weeks of
exploring the transcripts in relation to the maxims reduced the list from 17 to 10.

Step #9, setting up rule correlaries to the maxims, consisted of stating the maxims more formally. This included substituting symbols for phrases and combining several maxims into a single rule.

During the modification of rules (step #11), I made several attempts to organize the rules into a rule system. This effort was partially unsuccessful, possibly because the number of rules generated was insufficient to determine the relation of the rules to each other.

Step #12, illustrating the rules, resulted in a review of the transcripts to select examples which were representative yet obvious enough so that potential readers could examine excerpts out of context.

While the above description does not include all of the procedures in the study, it may provide some suggestions for other students who attempt this form of research. Although the attempts to categorize explicitly did not seem especially useful in this study, categorization remains both a necessary and useful activity in research dealing with narrower or more well defined talk activity.
Summary

Three problems associated with discourse analysis are: (1) little has been written about procedures used for deriving conclusions; (2) criteria for judging the validity and reliability of the method have not been established; and (3) few rhetorical conventions for making findings evidential are available to discourse analysts.

Nine criteria for making and interpreting observations are suggested to deal with the problems of validity and evidentiality. They are:

1. Conditions for obtaining data should be specified.
2. Relevant information about the sample should be provided.
3. Illustrations to demonstrate how the rules are consistent with the data should be used.
4. The internal coherence of the rules should be apparent.
5. The capacity of the rules to explain related theory should be demonstrated.
6. The predictive capability of the rules should be discussed.
7. A balance between subjectivity and objectivity should be attempted.
8. Detailed explication of examples should accompany the rules.
9. The heuristic value of the explanation should be indicated.
Because little is known about discourse analysis procedures, the last section of the chapter briefly describes the process actually used in this study.

Chapter III discusses the results of the study, and Chapter IV suggests implications of the results and conclusions about the method used.
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CHAPTER III

CHARACTERISTICS AND RULES FOR CO-SELECTION OF TOPIC

This chapter presents the results of the observations of topical talk in 16 medical interviews. The first section discusses three general characteristics of topical talk in medical interviews. The second section describes eight rules for the co-selection of topic to which doctors and patients conform.

General Characteristics of Topical Talk
in Medical Interviews

Because little previous research has focused on topical talk in extended discourse, it is necessary to precede the description of rules with three general observations. During the analysis, these observations appeared to be integral to all of the data and, thus, not sufficiently limited in scope to be explicated in the form of rules. The general observations are offered as a framework from which the rules can be viewed.

First, it was observed that any utterance of a patient or doctor may be heard as containing or implying medically relevant and, therefore, appropriate topic(s) on which a doctor or patient may comment. Even such
unlikely "talk" as a belch or the comment, "oh, darn," may be heard by a patient or doctor as implying medically relevant topics. For example, if a patient belches, a doctor may inquire about stomach trouble in general, eating habits, the effects of a recent laboratory test on the patient's digestion, or may ignore the belch altogether. The point is, that any utterance, here defined as including belches, sneezes, and so on, may be heard as medically relevant and, therefore, a potentially appropriate topic for comment by a next speaker in the interview.

In non-medical social talk utterances are heard differently. For example, in informal social talk a belch may be heard as a breach of social etiquette, whereas, in a medical interview it may be heard as an utterance warranting subsequent comment.

In medical interviews specifically, as in any form of social talk generally, a speaker cannot control how his or her utterance is heard and, therefore, cannot entirely control the comment of a subsequent speaker. The first observation simply states that a different set of implications is operative in a medical interview than in informal social talk generally. (The observation could be restated as an observation for social talk by replacing the term "medically relevant" with the term "socially relevant." ) For example, if a doctor says
"how have you been doing" and a patient says "my golf game's been off," the response may be heard by both speakers as socially relevant talk but not medically relevant talk. Hence, the above interchange would be appropriate when the doctor and patient are doing preliminary social talk, before the "interview per se" begins. The doctor usually signals a shift from the set of socially relevant implicatures to a set of medically relevant implicatures after such preliminary comments have been exchanged. If the same interchange were to occur during the medical interview, the doctor may hear the golf game comment differently because of the different set of implicatures which are operative. That is, she/he may hear it as implying something about the patient's health.

A second general characteristic of topical talk in medical interviews is that the nature of the medical relevance of a doctor's or patient's utterance is not clear to either speaker and, therefore, is not formulated until the patient or doctor takes his or her next speaking turn. That is, what a speaker says is retroactive both structurally and functionally. The function of a doctor's or patient's utterance is the subsequent speaker's utterance. Structurally what a doctor or patient says in an utterance is formulated in the subsequent utterance. This characteristic is illustrated
in the previous example. The function of the doctor's utterance, "how have you been doing," is not known until the patient comments on his/her golf game. Had the doctor's utterance ("how have you been doing") been preceded by the patient's utterance, "I'm off the tranquilizers," the comment about the golf game would have made little sense. Thus, the implication of what one speaker says is not clear until a second speaker has commented on it. In this way topics are jointly created.

A third general observation for topical talk in medical interviews is that within one speaking turn many possible topics may be implied for a next speaker. "What is said" in an utterance may include (1) content—things (objects, persons, concepts, activities) literally mentioned or alluded to, (2) manner—things relating to paralinguistic cues, (3) function—things dealing with the relationship of the speakers, or (4) omission—things that might have been said but are apparently absent for a next speaker. For economy I will refer to these things as "features" for topic implied in the production of an utterance. The following example illustrates how topical features can be observed in an utterance.

Consider the possible topical features for the question "How long have you been married?" A second speaker might respond in a number of ways including the following four.
1. "about 2 years"
2. "you seem hesitant to ask that"
3. "why do you ask"
4. "you mean to my present wife"

In the first hypothetical response the speaker refers to a content feature of the utterance. In the second, the speaker refers to a feature of manner by explicitly mentioning the way in which the first utterance was expressed. In the third, the speaker addresses a functional feature with a possible implication that the first speaker's utterance is not relevant or that she/he has no right to ask. In the fourth hypothetical response, the speaker addresses an apparent omission in the first speaker's utterance. These examples do not comprehensively describe all of the possible features implied in an utterance, but illustrate the variety of features available to a next speaker for comment.

The third general observation suggests that within a turn a speaker has a wide degree of elaboration available. That is, a speaker may comment on one or more of the topical features implied in the previous turn and may do so at great length. The length of a turn is apparently not controlled by topical considerations. This observation concurs with Sacks, Scheglof, and Jefferons's (1974) finding that turn size is not fixed but varies.
When a speaker extends the length and number of utterances in a turn, the features for topic for a next speaker increase and additional topics may be implied. The following examples illustrate the range of elaboration available to speakers in commenting on topics implied in previous turns. (See note 1, for an explanation of transcript notations.)

(1) D: how old are you
P: 38 (#21, p. 2)

(2) D: how old were you
P: I was 26, I'm 46 now, I've had it 20 years (#33, p. 2)

(3) D: where was it /the pain/
P: ah right in the center and then it seemed to spread all over, it seemed to spread up to my chest and then every once in a while a real sharp pain would go into my chest and my (heart) (#16, p. 2)

(4) D: uh where was the aching
P: in my lower back (#38, p. 2)

Examples 1-4 illustrate similar questions which are followed by both brief and more lengthy responses. Examples 2 and 3 are followed by more elaborate responses than 1 and 4 and, thus, may imply more features for topic in succeeding turns.

The following fragment illustrates a very long turn in which a great number of features for one or more topics are implied.
(5) D: how'd you do

P: well on the diet not too good because I didn't treat it as something that I thought was real, anything that was real serious, I did take care and uh put my insulin all the time, I always did that, but as far as diet I would cheat and everything like that. Course now after 20 years I've learned to live with it and I've learned more about myself and uh I know a great deal about myself as far as the diabetes goes where I can relate to the doctor. sometimes I think the doctor just treats the diabetic as a general thing. but I think when you know yourself, little symptoms and little things that work and don't work um, I mean I think it makes it easy for the doctor. an I'm prone to hypoglycemia because, I don't know what it is, I get nauseated and then I can't eat, then I don't eat and then I get this area of hypoglycemia and I've been into the hospital many times in coma. now about two weeks ago I was here and I was let out on Tuesday after being here eight weeks, uh eight days. I went home on a Tuesday and Wednesday I was back in a coma. now we felt that something was wrong but we didn't know what it was. now I had a radical (mastectomy) about four years ago and they've discovered since that I have a inner ear infection. and I'm going to ear clinic. I have been uh all week having treatments, and last week and they're going to decide today whether they're going to operate or not. and I believe they are to take care of this inner ear infection. it's the same ear (#33, pp. 3-4)

The content features alone in example 5 provide a wide range of choice for the doctor's subsequent turn. Recall that topics are retroactive. Thus, none of the features implied in the patient's turn in example 5 are functionally
features for topic until the doctor comments on them. The topic mentioned by the patient is the feature of the utterances in the turn which refers back to the previous utterance "how'd you do?"

The general observations are: (1) any utterance may be heard as implying appropriate topics for a medical interview; (2) the medical relevance of a topic is structurally and functionally retroactive; (3) within a single turn many features for topic may be implied for a next speaker.

These observations provide a framework from which rules for topical talk can be generated. The retroactive characteristic of topical talk indicates that features for topic in one turn are conditionally relevant to subsequent utterances in a next turn. Thus, the rules for topical talk take a conditional form, indicating the manner in which one speaker influences topic in relation to the other. The multi-featured characteristic of utterances and the retroactive nature of topic, point to the significance of Schegloff's (1972) phrase "co-selection of features for topics."

The following rules describe how doctors and patients co-select features for topic in the sample of transcripts and videotapes observed.
Rules for Topic Co-selection

Doctor Question Rule

Rule 1. When in a question a doctor asks about a topic (X), a patient is obligated to imply topic X.

Doctors usually ask about events familiar to the patient but not the doctor. If the patient cooperates, thus meeting the immediate needs of the talk exchange, she/he must deal with the topic implied in the doctor's question in order to continue the interview. In few instances did any patient in the sample fail to appear to address the topic implied by a doctor's question.

Examples 1-5 (pp. 57-58) illustrate the use of this rule. In example 1 the doctor asks about the patient's age and the patient mentions her present age. In example 2 the doctor implies the topic of the patient's previous utterance. The patient not only mentions her age at the time of the event described, but adds her present age and the duration of the illness she has just described. Examples 3 and 4 also show the patient implying the topic of the doctor's question.

In example 5 the doctor's question "how'd you do" implies the topic of the patient's progress in caring for her diabetes (the topic mentioned in the patient's previous utterance). The same topic is implied in the
patient's response in addition to other potential topics. Whether the additional potential topics are elaborated further depends on the doctor's subsequent turns.

When patients apparently violate this rule, doctors repeat the question.

(6) D: how bad does it get before you go to the hospital

P: uhm this has been, I ah haven't been in the hospital for asthma since 1966 its been pretty good since then . .

D: when you called /the emergency room7 could you do anything or did you have to lay in bed   (#21, p. 6)

(7) D: . . . how long have you had kidney trouble

P: well it just developed, um it started with a sore throat and continued on

D: when was that   (#19, p. 2)

In example 6 the patient does not describe her condition before she came to the hospital, but corrects the doctor's implication that there have been frequent hospitalizations. The doctor's second question confines the topic to the present hospital visit and replaces the original "how bad does it get" with "could you do anything." In example 7 the patient's response "just developed" is apparently not sufficient for the topic, "length of time with kidney trouble." Thus, the second question of the doctor asks for the time associated with
the start of the trouble. In both examples the doctors restate the topic implied in the original question.

A general rule for question utterances in medical interviews is apparently similar in structure and function to Labov's (1972) rule for requests for action or command utterances. Labov's rule is

If A requests B to perform an action X at a time T, A's utterance will be heard as a valid command only if the following pre-conditions hold: B believes that A believes (=it is an AB-event that)
1. X should be done for a purpose Y
2. B has the ability to do X
3. B has the obligation to do X
4. A has the right to tell B to do X

Labov states that these presuppositions appear in almost every rule of interpretation and production concerned with producing or responding to command utterances (pp. 302-303).

Just as a command is a request for action, a doctor's question is a request for a patient to perform the action of providing information. Given the presupposition for a medical interview—that the doctor must receive information in order to define a medical problem—patients may be said to be commanded to give the information requested. Thus, Labov's general rule may be translated for doctors' questions as follows:

If a doctor requests a patient to give information about X during a medical interview, the doctor's utterance will be heard as a
valid question if the following pre-conditions hold: the patient (P) believes that the doctor (D) believes (=it is a DP-event that)

1. information about X should be done for a purpose Y (where Y may be to define P's problem or to understand how the problem affects P's life
2. P has the ability to give information about X
3. P has the obligation to give information about X
4. D has the right to tell (or ask) P to give information about X

If a patient's interpretation of and subsequent response to a doctor's question indicates that one of the pre-conditions has not been met, the patient may postpone providing information about topic X. For example, a doctor may ask about a topic which a patient considers inappropriate (e.g., sexual habits), calling the third presupposition into question. The doctor may respond by stating why the information is relevant and, thus, functionally restates the question, as in the following hypothetical example:

D: do you know if you have ever had venereal disease

P: what does that have to do with my joint problem

D: arthritis sometimes relates to V.D.

P: well I may have, ....

Labov's general rule applied to medical interviews assumes that in interpreting a question, a patient understands the topic implied. If patients conform to Rule 1,
they must understand what topic is implied. Thus, contrary to Labov, the general rule may be modified by adding the presupposition that P must understand the implication for X.

Rule 1 also differs from Sacks' (1968) rule for question-answer sequences (a proper question obligates a proper answer) in a similar way by adding the presupposition that in answering a question a speaker must understand and conform to the topic of that question. The term "proper" in Sacks' rule may be more clearly understood if it is defined in terms of the topical presupposition.

Patient clarification rule

Normally when speakers do not understand a previous utterance, they ask for clarification. In the transcripts, patients postponed answers by inserting questions in the position reserved for answers. In this case a patient's question conformed to Rule 1 and is described in the following rule.

Rule 2. If a doctor asks about topic X, a patient may ask a question about X before answering the doctor's question.

By asking a question about the topic implied in a doctor's question, patients continue to conform to Rule 1 and are heard as responsive to the question.
They may postpone the obligatory demand of the question for at least one and occasionally more than one turn. The following examples illustrate the use of this rule. (The arrows indicate the patients' utterances which ask about the topic in the doctor's previous question.)

(8) D: ... what is the um what is the thing that brought you to medical attention
   → P: ah you want me to start at the first
   D: just tell me whatever you would like, what you are doing in the hospital (#19, p. 1)

(9) P: uh pizza, I get uh gas, uh acid sometimes in my stomach
    D: whereabouts
    → P: whereabouts
    D: point to where it bothers you
    P: I don't know (#38, p. 29)

(10) D: what is it now, your blood pressure
     → P: right now
     D: today or yesterday
     → P: about average
     D: yeah
     P: 150 over 100 (#36, p. 5)

(11) D: does this stay the same or is it getting worse
     → P: the hearing
     D: ya
     P: about the same, I've thought of that lots of times (#26, p. 19)
In example 8 the doctor's first question apparently causes a problem for the patient. The patient's subsequent question implies difficulty with the topic implied in the doctor's question. In this case the doctor has implied a very ambiguous topic—"the thing that brought you to medical attention." In rephrasing the original question the doctor re-defines the topic implying "whatever the patient would like to tell in relation to what she is doing in the hospital."

In example 9 the doctor's response to the patient's request for information about the topic implied takes the form of a command. As in example 10, the doctor's second turn functions to make the topic more specific. In this case the patient does not comply, but does linguistically conform to the same topic as implied in the doctor's question.

The patient's answer to the doctor's question in example 10 is postponed for two turns. The doctor's original question, "what is it now," is modified by the phrase "your blood pressure" which refers back to the indefinite pronoun "it." The patient's first question "right now" is positioned adjacent to the doctor's original question and refers back to the doctor's "now." The doctor subsequently clarifies or defines "now" as "today or yesterday." The patient then asks if the doctor's topic implied refers to the blood pressure rate
today or yesterday "on the average." The patient's second question is understandable if it is known (as later utterances make explicit) that his blood pressure rate fluctuates within a short time period.

The doctor's use of the term "this" and "it" in the original question in example 11 is also an apparent problem for the patient. Both pronouns refer to immediately adjacent nouns. In this case the patient's prior utterance deals with the use of his hearing aid. Thus, "this" in the doctor's question may refer to a number of ideas, objects, or activities in the previous adjacent utterances.

In examples 8-11 the patient's questions appear to deal with a problem in locating a feature for topic in the doctor's question. In each case the doctor has apparently completed his question and presumably intends to provide no further clarification of the topic implied. To be responsive to the topic implied in the question, conforming to Rule 1, the patient must place a question adjacent to the doctor's question.

**Doctor clarification rule**

Jefferson (1972) indicates that in informal conversation speakers deal with apparently problematic terms in the previous utterances by using repeat or clarification questions. Although Jefferson states that a speaker
in informal group interaction is not always obligated to answer a clarification question, in a medical interview a speaker usually is obligated to answer such a question. The following rule illustrates this practice.

Rule 3. If a patient asks a question about a topic implied in a doctor's previous question, the doctor must clarify the topic.

As the examples 8-11 (p. 65) above indicate, a patient may ask about the topic of a previous question either by repeating the doctor's question or by suggesting a possible implication of the topic and waiting for confirmation. In example 9 the patient repeats the doctor's question and the doctor clarifies "whereabout" by directing the patient to point to the location of the pain. In example 11 the patient suggests the topic implied as "the hearing" and the doctor confirms. If the topic implied in the doctor's original question was not "the hearing," presumably the doctor could have used his second turn to mention a different topic. By responding to the patient's request for clarification, the doctor functionally restates the question and Rule 1, the doctor question rule, is once again in force.

Patient ellipsis rule

Although Rules 1-3 indicate that doctors' questions have a good deal of control over topic, they do not
necessarily control the degree to which topics are defined and elaborated by patients. Patients may answer questions beginning with such phrases as "do you," "are you," or "have you" with elliptical responses. An elliptical response is defined as an utterance which omits a word or words necessary for the complete syntactical construction of a sentence, but not necessary for understanding. When patients use elliptical responses, they may be said to conform to the following rule.

Rule 4. If a patient answers a doctor's question with an ellipsis, the patient is heard as implying the same topic as the doctor.

Labov (1972) suggests that a general rule for elliptical responses is 'if A utters a question including a statement \((S_1)\) and B responds with an existential E (including yes, no, probably, maybe, etc.), then B is heard as answering A with the statement \(E-S_1\) (p. 300). If \(S_1\) is defined as the implied topic, a consequence of Labov's rule is that patients who respond elliptically to doctor's questions are heard as automatically implying the same topic. Stated another way, patients' elliptical responses are interpreted as accepting the doctor's formulation of the topic without adding additional topical features. Consider the following examples.
(12) D: do you use tobacco
   P: no
   D: never have
   P: no
   D: chew it, smoke
   P: no

(#26, p. 23)

(13) D: then you were 27 (when you had asthma}, ever have any trouble before you were 27
   P: no
   D: none at all
   P: nope
   D: perfectly normal breathing capacity.
   P: ya well I had hay fever
   D: how long have you had that

(#21, pp. 2-3)

(14) D: any illnesses in the family you can think of
   P: no
   D: goiters or diabetes or cancer
   P: no, not that I know of

(#36, p. 11)

(15) D: did you ever have anybody suggest taking your spleen out
   P: yea
   D: was it taken out
   P: no, they didn't take it out, it was ah serious stuff to take it out

(#17, p. 12)
Elliptical responses in these examples either confirm or deny the doctor's formulation of the topic implied in the question. Thus, the placement of an elliptical response after a question guarantees topic redundancy—that the topic implied in the doctor's and patient's turns are, for all practical appearances, the same.

Elliptical responses are efficient ways of answering doctor's questions and may be the most practical means of responding to simple factual questions where the patient can be assumed to have the information. But when the patient assumes the doctor's formulation of the topic implied, there is no way for the doctor to determine how the patient would formulate the topic in her/his own words.

**Doctor repeat rule**

In examples 12–15 the doctor repeats the original question. This practice is described in the following rule.

**Rule 5. If a patient answers a question with an ellipsis a doctor may repeat the same or a similar question.**

There are several possible explanations when doctors repeat questions. It may be that repeating is habitual, that during the course of medical training this practice
is observed and modeled. Thus, repeating may regularly occur without any apparent motive. A doctor may also repeat questions because she/he was not listening to the patient's previous answer.

Coulthard and Ashby (1975) suggest that doctors repeat questions because they cannot be sure what patients "mean" in their answers. This explanation assumes that it is possible to determine what is in the mind of the doctor at the time she/he repeats a question, but it is not supported by evidence.

Jefferson (1972) argues that when questions are repeated in informal group talk, there has been a problem in the preceding utterance. Repeated questions in her recordings were produced with a tone of "disbelief" or "surprise." This intonation did not characterize the conversations in this study. There was no evidence to support the explanation that doctors repeat questions when they do not "believe" the patient. From a topical perspective, repeated questions are restatements of the topic implied in the original question. A patient's use of elliptical response does not provide additional topical features.

Rules 1-5 demonstrate that doctors have considerable control over topics in interviews. Although patients may postpone answers by asking about the topics of the questions, they are ultimately obligated to
respond without adding topical features in ellipses, they may be asked the same or similar questions again.

The following rules indicate ways in which new topics are introduced into an interview.

**Doctor new topic rule**

It is conceivable that an entire interview could be conducted on a single topic. In none of the sixteen interviews however, did this occur. Although either the doctor or the patient may introduce new topics, they appear to conform to the following rules in doing so.

**Rule 6.** When a patient completes an answer, a doctor may use any part of the next turn to ask about a new topic.

Recall Sacks' (1968) observation that the questioner reserves the right to speak again (a necessary condition for two-party talk) after the second speaker has answered. If in the second turn a doctor asks a second question, a chain of QAQA develops. When the patient completes an utterance in which she/he has not asked a clarification question, the doctor is in a position to ask another question. The following examples illustrate ways in which doctors introduce new topics.

(16) The patient is relating his experience following a hemorrhoidectomy

P: ... he just packed it, that was it, in fact by the time he had looked it had stopped
D: is there any serious illnesses in your family of any kind, in your blood relatives like high blood pressure

P: my father uh had high blood pressure. . . . (#36, p. 11)

(17) The doctor is asking about the patient's experience with pregnancy

D: haven't had, haven't lost any [babies]

P: no

D: what does your husband do

P: he's a teacher (#34, p. 9)

(18) D: have you had any difficulty with your anemia

P: no

D: okay, let me just ask you a little bit about your past health, now except for the sickle cell have you ever had to be in the hospital

P: no, I was in an accident one time and I. . . . (#17, p. 15)

(19) P: uh, my blood pressure tends to run quite low

D: well that's good, how about your eyes, anything there

P: no, I believe they have stayed the same for the last ten years (#38, p. 10)

(20) The patient is discussing her feelings about being a diabetic

P: but it isn't a total thing with me that it captivates me
D: you mentioned you uh, you you uh emphasized that you reacted when your father died a great deal and that uh, 26 uh, the way you said it made me think that you, you felt yourself that reacted unusually compared to other people at 26, is why why do you think that uh

P: well because my father was an alcoholic and um he was. . . . (#33, p. 21)

Sacks et al. (1974) state that turns within a series regularly have a three-part structure: a first part which addresses the relation of a present turn to a previous one, a second part which occupies the present turn, and a third part which addresses the relation of the present turn to the next turn. Although a three-part structure was occasionally observed in doctors' turns, it often took an abbreviated form.

In examples 16, 17, and 20 the first part of the three-part structure is absent. In example 16 the doctor makes no comment relating to what the patient has just said. The doctor's question implies a topic ("serious illnesses in your family") unrelated to the immediate past sequence. In both 16 and 17 the doctors' questions combine the present and the future parts of the turn. Apparently a question utterance may assume the present part of a turn, when a present part might elaborate on a patient's previous comment.
Example 18 does display a three-part structure. The doctor's second turn begins with "okay" which comments on the previous turn. Doctors regularly say "okay" at the conclusion of patients' answers. One word responses like "okay," "right," "uhuh" appear to signal to the patient that she/he has answered sufficiently. The second part of the doctor's turn ("let me just ask you a little bit about your past health") relates to the present turn and can be said to announce a new potential topic. The third part of the turn contains a question implying a topic for the next turn.

We can compare the first part of the doctors' turns in examples 18 and 19. The one in 19 contains more complete comments on the patient's previous turn than does the one in 18. The one in 19 also displays a second and third part in the remainder of the turn.

Examples 16 and 17 illustrate the way in which new topics were implied most often in the sample. Doctors may apparently defer using a first turn part which shows the relation of the present turn to a past turn. When they do comment on a past turn, they may do so minimally, e.g., with a brief closing remark. Question utterances implying a new topic may also combine the second and third parts of the turn structure. When this occurs, as in examples 16 and 17, patients may be forced to adjust quickly to a new topic.
It is possible that during the course of an interview topics may assume different levels of significance for the doctor and patient. Asking about the condition of a patient's eyes, as in example 19, when there is no apparent reason to believe that the patient's eyes are an important problem, may be an occasion for a doctor to minimize or delete the first and second parts of the turn structure. When a topic may be assumed to be of greater significance by a doctor, a more complete turn structure may be used. The observations in this analysis suggest this notion but do not provide conclusive evidence for the formulation of a rule.

After a topic is introduced, doctor's turns connect to past and future turns but generally omit a present turn-part. Consider the following extended fragment.

(21) The doctor and patient are discussing the pressures associated with the patient's job as a high school English teacher.

D: the kids get under your skin once in a while

P: well I, no more than any other teacher (3 sec.)
D: do you share all this with your wife

P: yeah

D: what does she say

P: well she uh first thought it was her fault (laugh)

D: why did she think that

P: cause she thinks she nags, but she doesn't

D: but she doesn't (upward intonation)

P: no (laugh) no more than any other woman uh uh the way I understand (laugh)

D: (laugh) uh gee tell me about that, tell me about that

P: well uh nothing there's nothing to tell, she just uh she, nothing, she just figured she was the fault of it and then that was it

D: fault of (upward intonation)

P: the cause of it

D: cause of what

P: the blood pressure

D: well what does she think she, what does she uh what does she //
P: nags

D: like for instance when she nags what does she do

P: well, I don't know, keeps wanting me to uh work I suppose around the house (exhale) would be one example, but that has nothing to do with it (7 sec.)

D: how many children do you have (#36, pp. 7-8)

In his second turn in this fragment the doctor implies a new topic. The patient's response follows the elliptical rule adding no addition features to the topic implied in the doctor's question. The doctor's second question assumes the implication of the patient's previous turn (that he "shares" or talks to his wife about "all this"), omits an explicit present part (e.g., "tell me" or "what I'd like to know is"), and in the third part implies a topic for the patient's next turn. All of the doctor's turns function as questions in this fragment and generally omit a present part of the turn.

Patient's turns also appear to display a two-part structure: one relating to the past turn and one occupying the present turn. Whether the present part of a patient's turn becomes a topic for the next turn is apparently an arbitrary choice for the doctor. The seven-second pause before the doctor's last question in example 19 may indicate that the doctor is deciding
whether to continue the same topic or suggest a new one. Such pauses did not regularly appear in the transcripts, however.

Although doctors' questions may imply a three-part structure, they often abbreviate the past and present parts. In abbreviating past and present parts of turns, it may be that the relation of the turn to previous talk is not understood. This may be especially problematic for the patient when a doctor implies a new topic. When a doctor's turn omits a past part of the structure, the patient has no way of knowing how his/her turn was heard by the doctor. Stated another way, the doctor apparently is not obligated to connect new topical sequences to past ones. Thus, doctors may maintain a great deal of control over what the patient says. This observation suggests that the doctor-patient relationship may be defined in terms of the amount of control imposed by the doctor.

Apparently doctors may arbitrarily introduce new topics at any time in the interview without necessarily establishing the relation of the new topic to previous talk. Thus, patients are limited in understanding the relevance of questions when a three-part structure does not connect the turn of the doctor to previous talk.

Sacks, et al. (1974) observation that turns regularly display a three-part structure does not hold for
the sample of interviews observed in this study. Sacks' observation apparently included a variety of informal conversations involving more than two parties. Although his claims for turn structure were generalized to a variety of situations, they apparently do not apply to the doctor-patient interview nor, perhaps, to other situations where one party exercises more control than the other.

**Patient new topic rule**

Patients may imply new topics without violating other rules in the system. Because of Rule 1, patients must meet topical demands in a prior question of the doctor. Thus, patients may not use the first part of a turn to imply a new topic. The following rule describes how patients may imply new topics.

**Rule 7. Patients may imply new topics only after commenting on the topic implied in the doctor's previous turn.**

The following examples illustrate the use of this rule. (Arrows indicate places where new potential topics are implied.)

(22) D: how about the ear anything there that you're aware of
P: pain very much pain in the and they go in there and clean it out everyday it and everything, it really is terrible it is a very awful thing and uh I'd just gotten my diabetes way off but also I've noticed something that I can't understand, Dr. Leonard, is I'm getting older I'm on less insulin than I was when I first got it I mean in other words my insulin's been up and down, up and down through the years/

D: but/

P: I'm only on 20 units of insulin now

D: what kind

(23) The doctor and patient are discussing pain and swelling in the patient's knees

D: how about the first thing when you get up in the morning, how does it feel then

P: well, it feels good

D: does it

P: yeah, no I feel real good in the morning and but uh the thing that uh I it well it's uh getting away from the subject but my back is long the same order

D: okay, well what about your back

(24) The doctor and patient are discussing the patient's recurrent respiratory infections

D: has it been like now or is it getting worse

P: well it seems to have gotten worse and I'm not as active

→ Now I discover now that I can't run, it seems like a kind of an inane thing to talk about but one day I tried to run for the bus and when I come from clinic, I go to medicine clinic, and I wanted to run for the bus because it was coming and I just don't have the stamina to run any more
D: what happens if you run  (#36, p. 4)

(25) D: what kind of work do you do

P: I'm a school teacher

D: where abouts

P: Johnstown, or I was, I'm moving ←
this year

D: where are you moving to  (#36, p. 5)

In examples 22-25 patients imply a new topic in the last part of the turn. In examples 23 and 24 the patients indicate that they are aware of a topic shift. The patient in example 22 connects the new subject of insulin dosage with the phrase "but also I've noticed something that I can't understand." In example 23 the patient acknowledges that he is leaving the topic implied by the doctor with the phrase "well it's uh getting away from the subject but." The patient's phrase "it seems like kind of an inane thing to talk about but" in example 24 almost appears to apologize for shifting the topic.

In example 25 the patient may not appear to be changing the subject, but the last part of the answer does function to change the subsequent sequence of talk to the topic of the patient's "move" as indicated by the doctor's following question. It is possible that the manner in which a patient formulates a response may call attention to a new potential topic for the doctor. Presumably the patient could have mentioned just the
name of his future location or "I have been in Johnstown, but I'll be in Morgan next year" without drawing the doctor's attention to "moving" as a potential topic.

Patients may imply new topics overtly as in examples 22, 23, and 24. Whether they do so intentionally is unclear in the discourse of examples 23 and 25. As the general features of topical talk indicate, topics are functionally and structurally retroactive. Thus, the act of implying a new topic is constituted in a following turn.

**Doctor topic defer rule**

Patients may imply a new topic within a turn. Whether the new topic is constituted depends upon the doctor's subsequent turn. When a doctor does not comment upon a topic implied by the patient, we may say that the doctor ignores or defers the potential topic. The following rule describes how doctors may respond to new topics implied by patients.

**Rule 8. If a patient implies a new topic, a doctor is not obligated to comment on the topic.**

Although doctors do comment on new topics implied by patients, they may also ignore them. This occurred in the following examples.
(26) D: after the rheumatic fever were you on any medication
P: no, none for the rheumatic fever, but I've been on iron pills
D: were you ever advised to uh take penicillin if you were going to have a tooth out or anything like that
P: mm no (#34, p. 14)

(27) The patient mentions having surgery following a car accident
D: other than that /operation/ you've been healthy
P: yea, I never catch colds or anything but now I keep a cold and have sinus trouble and everything else
D: what kind of operation did you have
P: ah they said that I was bleeding internally and they were going to cut me open to see if I had glass inside me (#17, p. 16)

(28) The patient is discussing her problem in maintaining a diabetic diet
P: ... I mean getting the pots and pans out and doing it and I've been quite lonely and I think there's a little bit of a problem there, an emotional problem, uh I think that's what you more or less call it
D: what's the longest you've ever gone without having a hypoglycemic spell
(4 sec.)
P: mm maybe six months (#33, p. 7)

Following Rule 7, patients imply new potential topics after commenting on the topic implied in the doctor's
previous question. In examples 26, 27, and 28 the patients imply potential new topics which presumably are medically relevant. Thus, there is no apparent reason for the doctor to ignore them because they are inappropriate topics for an interview. In each case the doctor's next question is related to the topic implied in a previous question. Although it is possible that doctors could follow the patient's introduction of a potentially new topic with yet another topic, in no instance in the 16 interviews did they do so.

In example 26 the doctor did ask about the patient's loneliness several turns later. This suggests that doctors may simply postpone discussing a topic implied by a patient. In this case the patient had no verbal indication that the topic she raised would be discussed until the doctor introduced it later. By postponing a topic for a later question, a doctor maintains control because it allows the doctor to phrase the topic in his/her own words.

Summary

Results of the analysis of 16 medical interviews indicated that three general observations of topical talk provide a framework for the derivation of eight rules. The three general observations are: (1) any utterance may be heard as implying appropriate topics for a medical interview; (2) the medical relevance of a topic is structurally and functionally retroactive; and (3) within a
The eight rules are:

1. When in a question a doctor asks about a topic (X), a patient is obligated to imply topic X.

2. If a doctor asks about topic X, a patient may ask a question about X before answering the doctor's question.

3. If a patient asks a question about a topic implied in a doctor's previous question, the doctor must clarify the topic.

4. If a patient answers a doctor's question with an ellipsis, the patient is heard as implying the same topic as the doctor.

5. If a patient answers a question with an ellipsis, a doctor may repeat the same or a similar question.

6. When a patient completes an answer, a doctor may use any part of the next turn to ask about a new topic.

7. Patients may imply new topics only after commenting on the topic implied in the doctor's previous turn.

8. If a patient implies a new topic, a doctor is not obligated to comment on the topic.

The rules illustrate an asymmetry in the doctor-patient relationship; that is, separate rules apply to each party. Doctors may imply topics with relative assurance that patients will comment on them. Patients do not have the same assurance that the topics they introduce will function to produce a sequence of topical talk.
The rules account for some of the ways doctors control what is said in the interview. They suggest that doctors have a wider range of options in raising, continuing, and connecting topics than do patients. Although patients may control, in part, the extent to which topics are developed, if topics are underdeveloped, doctors may continue to ask questions on the same topic.

Several observations derived by other researchers do not seem to apply in the medical interview. Coulthard and Ashby's (1975) and Jefferson's (1972) explanation for repeat questions were not supported by the results. Sacks et al. (1974) observation that speakers regularly use a three-part turn structure does not appear to occur in medical interviews or, possibly, in other situations where one party has more control than the other.

Chapter IV discusses several implications of the rules and conclusions about the method used to derive the rules.
REFERENCE NOTE

1. The following symbols were used in the transcripts:

    \[ \] words in brackets were added by the analyst

    (...) words in parentheses indicate what was probably said, but was not clear in the recording

    // double slash indicates point at which the following line interrupts

    (no.) indicates the length of pause in seconds

    (#1, p. 2) indicates the transcript and page number
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CHAPTER IV

IMPLICATIONS OF THE RULES AND CONCLUSIONS ABOUT DISCOURSE ANALYSIS

Introduction

The first section of this chapter discusses three conceptual implications suggested by the set of rules derived in Chapter III, and evaluates the use of the rules as elements for a theory of topic formulation. The second section reconsiders discourse analysis procedures and describes several strengths and weaknesses of the method.

Conceptual Implications of the Rules

The first implication of the rule set is that Rule 1 (the Doctor Question Rule) takes precedence over the other rules. This implication is derived from an examination of the relationship of the rules to each other. It is only when Rule 1 is in force that Rule 2 (the Patient Clarification Rule) may be used. Rule 3 (the Doctor Clarification Rule) is dependent on the use of Rule 2. Rule 4 (the Patient Ellipsis Rule) is also dependent upon a prior use of Rule 1 but not necessarily on Rules 2 and 3. Rule 5 (Doctor Repeat Rule) is usually used only
after Rule 4 although doctors may repeat questions at
times other than after patients' elliptical responses.

Rules 7 (Patient New Topic Rule) and 8 (Doctor Topic
Defer Rule) also assume a prior use of the Doctor Ques­
tion Rule (Rule 1). Recall that patients imply new
topics after commenting on the topic implied in a doctor's
previous question (Rule 1). Accordingly, doctors defer
topics (Rule 8) only after patients imply new topics
(Rule 7). In effect, Rules 2, 3, 4, 5, and 7 are subor­
dinate to Rule 1. The remaining Rule 6 (Doctor New
Topic Rule) may be viewed as a variation of Rule 1, since
it is assumed that once a new topic is implied by a doctor,
Rule 1 (the Doctor Question Rule) will be used.

The rule set allows for a degree of variation in how
topics are co-selected. For example, topics may be
re-cycled. A minimal sequence for re-cycling a topic
would take place when Rules 1, 2, and 3 follow in sequence.
In other words, a doctor may imply a topic in a question
(Rule 1), a patient may ask for clarification of the
topic (Rule 2), which obligates the doctor to clarify
the topic (Rule 3) and functions to restate the original
question (Rule 1). The Doctor New Topic Rule (Rule 6)
and Patient New Topic Rule (Rule 7) may also function to
re-cycle a topic discussed earlier in the interview.
The Doctor Repeat Rule (Rule 5) explicitly performs the same function.

The importance of the Doctor Question Rule suggests the following view of the medical interview. The patient comes to a doctor with a problem. In seeking help the patient relinquishes certain rights, among them the right to control, in part, what information he/she will have to give in order to receive help. The doctor must take the problem from the patient and shape it into a form that he/she can deal with (e.g., diagnose, treat, or dismiss as nonmedical). It is necessary that the doctor shape the problem into a form that is for him/her solvable. The interview is, in essence, a negotiation of words (e.g., topics) so that the doctor can take the patient's problem and turn it into something he/she can deal with successfully. If patients insist on defining problems in their own terms (e.g., challenging the doctor's right to topic control), they risk being labeled uncooperative. Hence, topic construction in the medical interview is related to a higher function of problem formulation.

A second implication of the rule set is that the three-part turn structure suggests a way to study the concepts of status and power. This implication is indicated in considering the function of doctors' questions within a turn. Recall that a question connects to
adjacent turns (past and future) while often omitting a present turn part. By omitting a present part of the turn in a question, a doctor omits adding content which contributes to the formulation of the topic. The following two examples illustrate how this works.

(1) 
P: well she uh first thought it was her fault (laugh)
D: why did she think that (#36, p. 7)

(2) 
P: well she uh first thought it was her fault (laugh)
D: well it isn't unusual for family members to feel responsible for a serious illness. was there any particular reason she thought that

Example 1, taken from a transcript in the study, illustrates how questions typically omit a present part of a doctor's turn. Example 2 is a hypothetical illustration of how a turn might include a present part and still address the same question. In omitting a present turn part in the utterance of a question, a doctor ties the past (content from the previous turn) to the future turn without revealing any information regarding the connection of the adjacent turns.

Metaphorically, the doctors' questions seem to function like an improvisational director's instructions in a cinema production. The director tells the actor what occurs in the prior scene and what scene follows. The actor fills in the middle. At the conclusion of the drama,
the actor may or may not know how the sequence of scenes reveals a story.

A doctor's turn which consists of a question eliminating explicit comments on the patient's previous turn, functionally ties the past and future without providing any rationale for the relevance of such a connection. Thus, doctors in interviews (and possibly speakers in other types of social interaction), who regularly omit present-turn parts, have great power over the course of the conversation. If patients acquiesce to this procedure, as did those in this study, they relinquish control over how their problems are formulated.

More detailed description and analysis of turn-part structure may provide important clues to how status and power are developed in relationships. For example, defining status as the use or lack of use of three-part turn structure, would allow the analyst to study "status" as a phenomenon created by interaction rather than as a hypothetical construct assumed to exist because of personality variables or social position. Analyzing "status" or "power" as a creation of the interaction would permit researchers to pose questions concerning the conditions under which status differences are produced, controlled, and recognized.
A third conclusion suggested by the rule set emphasizes the importance of the "double interact" as a basic unit of analysis in discourse. Watzlawick, Beavin, and Jackson (1967) argue that the stream of communicative interaction is a series of overlapping stimulus-response-reinforcement triads. Similarly, Hollander and Willis (1967) describe the double interact as a fundamental unit for analyzing interpersonal influence. Weick (1969) argues that since organizing (or organizational behavior) involves control, influence and authority, the double interact is the minimal unit for specifying observable behavior in organizing phenomena (p. 33). McGrath and Altman (1966), in their critique of small group research, have also emphasized that there are "strong conceptual reasons for preferring dyadic or polyadic units" (p. 74).

A strong conceptual reason for using double interacts or three-turn units is suggested in the results of this study. The rule set for topic co-selection and the retroactive characteristic of topical talk indicate that three turns (e.g., double interacts) are required before either the speakers and/or the scholar can determine how topics are structured. A single speaker, A, can merely imply but not constitute a topic in a single turn. In a second turn B elaborates, modifies, or rejects A's topic. At the conclusion of two turns (an interact) A knows how
his/her topic is heard, but B does not yet know how
his/her elaborating, modifying, or rejecting is heard.
Thus, a third turn (e.g., a double interact) is required
before B can recognize the function of his/her turn for
the structure of the topic. Three consecutive turns are
required before both speakers indicate to each other what
they are talking about. This observation provides empiri-
cal evidence for the claims above and lends support to
Hawes' (1973) postulate of concatenity. Hawes, however,
emphasizes the importance of the interact rather than the
double interact. The results of this study indicate that
researchers must go at least the next step if they are to
use speech behavior as primary data to generate explanations
for large units of behavior (e.g., interpersonal control
and influence, small group and organizational decision
making).

These three conclusions indicate that (1) topical
structure may function on a higher level of problem formu-
lation; (2) question structure in a turn system may pro-
vide important clues to the investigation of status and
power in dyadic relationships; (3) three consecutive turn
structure (or double interacts) rather than interacts
is the minimal units for study of a wide variety of
communicative events. The usefulness of these conclu-
sions provides evidence for the usefulness of discourse
analysis.
But discourse analysis has a more functional use—the systematic description and explanation of social talk. Thus, social scientists, who criticize the primitive uses of the method may take comfort in its potential for discovering new concepts and variables which can be pursued through more traditional methods. Others may be intrigued with the possibility of generating theories of social communication as discourse analysis procedures become more refined. A discussion of these procedures will be addressed in the final portion of this chapter.

To what extent do the eight rules contribute to an understanding of how topics are formulated in conversation? One answer to this question is that the rules make a contribution to the extent that they help in explaining topic formulation. Accordingly, the most satisfactory explanations in social science are theories. The question then becomes, how do the rules relate to any kind of theory of topic formulation?

Using Hawes' (1975) definition of theory as an explanation of a phenomenon, we may say that a theory is a set of statements and the specified logical relations for combining those statements. In constructing theory researchers look for the most parsimonious combination of theoretical statements. If each of the eight rules in Chapter III is considered a candidate for a
theoretical statement, how close are we to having a theory of topic formulation in medical interviews whose constituted elements are rules?

Not very close. In their present form the rules may not be considered as candidates for theoretical statements because the rules do not move much beyond the level of empirical generalization. Though they describe some characteristics of topical talk in the 16 interviews, they do not account for more abstract relationships of topic production and interpretation by speakers. Thus, the rules may be considered as shorthand abstractions for understanding surface level variations in the phenomenon. As such, the rules are logical first steps in the process of developing theory. A next step is to account for the relationships among the rules (e.g., the relative power of each rule) in order to generate a rule system. A further step requires the combining of rule systems (e.g., topical rule system and turn rule system).

These steps are consistent with Toulmin's (1974) argument for a seven-leveled or heptachotomic theory of human behavior. Each level is viewed as a different order of explanation with the different orders subject to a one-way relationship of growing complexity (p. 200). The complexity of a theory of social talk in medical interviews from a topical perspective alone is too great a task for a single study. Hence, the rules in this
study may be viewed as a first-step in the generation of more complex explanations. The following section provides several suggestions for refining discourse analysis procedures in order to generate such explanations.

The Method of Discourse Analysis in Retrospect

Chapter II discussed problems associated with discourse analysis. These could hardly be resolved in a single study. Yet wrestling with those problems in this project did produce several insights about the method and procedures of discourse analysis.

Discourse analysis procedures

Recall that a challenge for the discourse analyst is to keep what is done in an utterance distinct from what is said (Labov, 1972). To adopt this perspective the analyst first relies on her/his own intuition as it is confirmed in the discourse. Yet to move beyond the intuitive level the analyst must somehow become "estranged" to the tacitly known background features of the talk in which she/he is attempting to find order. In other words, even though the discourse is similar in form to everyday experience, the analyst must adopt a perspective similar to that of the anthropologist observing a foreign culture.

Near the conclusion of the analysis I found the following procedures to be helpful in making the discourse
"strange" or "problematic." These procedures are suggested here, hopefully, to aid others in avoiding some of the "blind alleys" I encountered.

First, short sequences of talk should be observed for relatively short periods of time. When long sequences of talk (e.g., several pages of a transcript or an entire interview) are examined, the analyst may begin to lose the perspective of the "strange" and begin to view the discourse in light of the content of utterances rather than the form.

Similarly, focusing on a short sequence for a long period of time (e.g., more than a few minutes) also appears to diminish the ability of the analyst to "see" what is being done in utterances. Examining short sequences for short periods of time may seem contrary to a researcher's training and the attendant conviction that "if one looks long enough and hard enough, one can make noticeable progress." Like the anthropological stranger, the discourse analyst must be willing to wait for patterns to emerge and must develop a disciplined set of operations for making the observations.

Second, the operations of examining the discourse and describing what is observed should be performed concurrently. That is, following the short periods of observation, the analyst should write detailed accounts
of what she/he has observed. Brief journal notes collected during this study were helpful in that they kept a record of tentative conclusions. But practising detailed description of sequences of talk may give the analyst rehearsal in explicating the organization of talk. The activity of writing forces the analyst to organize what she/he observes and simultaneously sharpens her/his ability to examine the discourse.

As the examination of utterances becomes more focused and tentative rules are formulated by refining the descriptive accounts into more formal explication, the analyst may also benefit by "testing" the rules in a variety of situations. Testing may be done by (1) inventing hypothetical utterances which both conform to and violate tentative rules, (2) by trying to use the rules in actual situations, and (3) by asking others (qualified researchers and lay persons) to critique the written accounts.

**Discourse analysis problem selection**

The above suggestions deal with the procedural problems associated with discourse analysis. An equally important consideration relates to the level and scope of examination selected for study. This study attempted to derive general rules for thousands of utterances in 16
complete interviews. Previous analyses have selected much smaller communicative activities, such as, single speech acts in a variety of settings or a single event (e.g., a family dinner conversation or a group therapy session). If the discourse analyst's goal is to develop highly refined and comprehensive rules, accompanied with detailed evidence, he/she must select a manageable or carefully limited problem for investigation. This is not to say that more general investigations are not useful. It simply emphasizes that if the scope of investigation is not well defined, the analyst sacrifices detail in explicating the findings. As the detail of explication of rules increases, the problem of evidentiality discussed in Chapter II may diminish.

**Conclusions about discourse analysis methods**

Chapter II argues that the problem of evidentiality for discourse analysts is rhetorical. The rhetorical dimension is manifested in at least two ways. First, the student using discourse analysis must continue to deal with the lack of agreed-upon conventions for procedures. While this may also be perceived as an advantage (e.g., the student is not locked into a prescriptive set of steps), it leads to many blind alleys in the course of the analysis. Thus, the student though challenged to
use her/his own creativity and ingenuity, ultimately runs the risk that unconventional procedures will be judged unacceptable by the scientific community.

A related problem associated with evidentiality is that students in most graduate programs are offered relatively little training in the analysis and description of discourse. In this study an exceedingly difficult problem was the explication of examples. More simply, it is difficult to write about "talk." The student is often forced to "re-define" conventional terms in non-conventional ways (e.g., the use of "utterance production" as "action") or to invent "new" phrases which may be more confusing to a reader (e.g., "formulating topic"). While conventional terminology may be more easily accepted, the richness of ideas is often sacrificed in conforming to conventional usage. As terminology is clarified and used more consistently, this problem may diminish.

These problems associated with evidentiality—(1) the absence of conventional procedures, and (2) the lack of terminology—should be considered in relation to the goals of discourse analysis. The goal of discourse analysis is to understand how social talk is organized. The first step towards this goal is to describe. In describing, the discourse analyst resists
premature quantification and must, therefore, be willing to deal with the above problems. As Labov (1972) suggests, "no useful purpose would be served by counting the number of questions that someone asks in an interview. The relation of argument and discourse to language is much more abstract than this and such superficial indices can be quite deceptive. When we can say what is being done with a sentence, then we will be able to observe how often speakers do it. . . ." (p. 305).

The systematic description of social talk in the Communication discipline is of particular importance. Communication scholars traditionally study social talk using interaction analysis methods with coding procedures based on content or grammatical forms (Rogers and Farace, 1975). Discourse analysis findings demonstrate that grammatical actions are not necessarily synonymous with social actions. Thus, discourse analysis may generate interaction coding systems based on the relation of the content and form of language in social talk. Stated another way, discourse analysis may aid in explaining the relationship between language and speech.

Summary

This study demonstrates one way discourse analysis may be used to account for some of the communicative behaviors of doctors and patients in medical interviews
and provides suggestions for how the method can be refined. As it is refined, the value of the method will be reflected in its ability to contribute to practical knowledge which complements traditional empirical and theoretical approaches. The value of the results must be tested in other settings using other approaches. Chapter V will suggest several possible approaches for validating the results.
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CHAPTER V

SUMMARY AND DIRECTIONS FOR FUTURE RESEARCH

This chapter is in two parts. The first section summarizes the study. The second section identifies directions for future research. Several research questions which extend and clarify the rules for co-selection of topic are suggested and four alternative approaches to the study of language-use in social contexts are discussed.

Summary

The present study begins by asking how doctors and patients co-select topics in medical interviews. The report includes four parts. Chapter I provides a perspective for viewing language-use as rule-conforming behavior. Chapter II evaluates discourse analysis as a method for deriving rules and outlines procedures for the present analysis. Chapter III presents three general characteristics of topical talk and eight rules for co-selection of topic derived from the analysis of 16 medical interviews. Chapter IV discusses conclusions about the rules and the method.
Social talk as rule-conforming

The organization of language in social situations, or talk, is not only a linguistic but a social activity. Language-use requires social coordination as well as linguistic competence. Scholars have identified a number of structural components with identifiable functions in the system of social talk. Their observations have been described formally as rules. Thus, rules aid in explaining the social coordination that augments linguistic production.

Rule explanations are derived from observations of ordinary language activity in naturalistic settings. The rules provide formal accounts of how one behavior (e.g., an utterance) follows another from the perspective of the members who use them. Thus, rules can be used to explain a variety of human actions, from simple sequential regularities to consciously planned rational behaviors (Toulmin, 1974).

Although there are many levels of rule explanations, this study argues that topic coordination in medical interviews can be understood as rule-conforming behavior. A rule-conforming explanation suggests that there are a range of alternative behaviors for topical talk which are conventionally used in interviews. Thus, the rule perspective does not provide evidence that a rule
paradigm is the most appropriate metaphor for explaining language-use, but proceeds on the assumption that it is possible to understand topic formulation in interviews "as if" persons are conforming to rules. A description of the methods doctors and patients use to coordinate topics during interviews is a reasonable application of this perspective.

The work of several scholars who have employed the rule perspective is discussed to allow the reader to understand how others have used it and to provide a conceptual base for proceeding with the present analysis. The organizational characteristics of talk, described in previous work, are assumed to apply in medical interviews. But questions concerning how topics are raised, preserved, and shifted in the interview context are unanswered in this work. The second part of the study proposes a method for investigating the structure of topic in medical interviews.

**Evaluation and application of discourse analysis**

The organizational characteristics of social talk discussed in Chapter I were derived by using discourse analysis. Essentially discourse analysis is the observation and detailed description of language activity in transcripts of naturally occurring speech events.
Chapter II discusses three related problems associated with discourse analysis. First, little is known about discourse analysis procedures. Second, criteria for judging the reliability and validity of the method have not been determined. Third, the evidential basis for discourse analysis findings is often weak. To deal with evidentiality, discourse analysts have usually relied on the readers' ability to recognize the validity of the analysts' claims. Thus, it is argued that the problem of evidentiality is essentially a rhetorical problem.

To confront the lack of criteria and the associated problem of evidentiality, nine criteria for judging discourse analysis are proposed. The problem of discourse analysis procedures is addressed by retrospectively describing the operations used in this study.

Sixteen videotapes and transcripts of doctor-patient interviews were used for analysis. After exploratory inspection of four transcripts, 12 preliminary steps were outlined. Attempts to identify functional categories in the discourse were unsuccessful. Subsequent analysis included several techniques which aided the analyst in observing the utterances from different perspectives. Throughout the analysis, observations were recorded in a journal. These observations were then organized into
a set of maxims. Rules were generated by describing the maxims more formally. Testing of the rules was done by comparing them with the transcripts.

Results of the analysis

The analysis of the interviews resulted in the derivation of three general characteristics and eight rules for co-selection of topics in medical interviews. The rules are accompanied by examples from the transcripts. Detailed explication of the examples illustrates how the rules were used. The three general characteristics are: (1) any utterance may be heard as implying appropriate topics for a medical interview; (2) the medical relevance of a topic is structurally and functionally retroactive; and (3) within a single turn many features for topic may be implied for a next speaker.

The eight rules are:

1. When in a question a doctor asks about a topic (X), a patient is obligated to imply topic X.

2. If a doctor asks about topic X, a patient may ask a question about X before answering the doctor's question.

3. If a patient asks a question about a topic implied in a doctor's previous question, the doctor must clarify the topic.

4. If a patient answers a doctor's question with an ellipsis, the patient is heard as implying the same topic as the doctor.

5. If a patient answers a question with an ellipsis, a doctor may repeat the same or a similar question.
6. When a patient completes an answer, a doctor may use any part of the next turn to ask about a new topic.

7. Patients may imply new topics only after commenting on the topic implied in the doctor's previous turn.

8. If a patient implies a new topic, a doctor is not obligated to comment on the topic.

The rules for topical talk reveal an asymmetry in the doctor-patient relationship. Although patients are able to postpone mentioning topics introduced by doctors they are ultimately obligated to comment on them. The rules indicate that doctors may have a wider range of options in raising, continuing, and deferring topics than do patients in initial interviews.

Conclusions about the rules and the method

Three conceptual implications suggested by the rule set illustrate the usefulness of discourse analysis in discovering new concepts and variables which can be pursued through more traditional methods. The conceptual implications are: (1) topical structure appears to be related to the problems the conversants need to solve; (2) question structure in a turn system seems to provide ways of investigating the development of status and power in relationships; and (3) three consecutive turn structure (or double interacts) seems to be a minimal unit of analysis in studying communicative behavior.
Although discourse rules appear to generate and to aid in the operationizing of new concepts, a more important use of the method is the systematic description and explanation of social talk. While the rules in this study were not sufficient to be considered candidates for theoretical statements, discourse rules may eventually serve this function.

A reassessment of the problems associated with the method argues that the discourse analyst must develop more systematic procedures. Several suggestions are proposed for improving operations. Reconsideration of the problems associated with evidentiality, indicates that the lack of conventional procedures and the absence of terminology for describing social talk are likely to continue to challenge discourse analysts.

**Directions for Future Research**

Because the social organization of talk is a relatively new area of study, much additional research is needed. Although discourse analysis is a primitive method, it suggests a number of important questions which require examination.

**Extending the rule set**

As larger samples of data are examined in greater detail, the rules for co-selection of topic may be
validated, modified, and extended. We need to know how speakers recognize topics in interviews and other forms of conversation. Extensions of the rule set above should account for other methods of structuring topics (i.e., how topics are asserted, preserved, and closed).

As the rules are extended, questions which examine how topic co-selection influences the relationship of parties in interaction may be pursued. This study considered methods of structuring topics in 16 single encounters between strangers. It may be that rules change with the history of a relationship. Although doctors appear to exert control over topics when they are formulating problems, they may modify such influence as problems are defined. Similarly, patients may establish ways of influencing topic co-selection as they assume a shared understanding of the relevance of topics in interviews.

Other questions for further research should consider whether rules for co-selection of topic in medical interviews apply in other situations. Do the rules account for how topics are structured in other encounters where one party seeks help from another in relation to a problem (e.g., faculty/student conferences, attorney/client consults, parent/child conversations)?

The situational relevance of rules may also be influenced by the language competencies of the
interactants. If, as an implication of the results suggests, topic co-selection has a higher function of problem formulation, it may be that rules are more restricted in environments where one party has a highly specialized language for expressing problems. Thus, the technical language used by doctors may influence the way in which problems are defined or expressed and the ways in which topics are constrained. It may be that interviewers with less specialized vocabularies impose less control over topic co-selection. A comparison of other environments seems warranted to examine how the definition of a situation and the language competence of speakers influence rule-conforming language-use.

Alternative methods

The questions above may be addressed using a number of methods in addition to discourse analysis. Four approaches seem interesting.

First, the validity of the rule set in this study may be partially tested using stimulated recall (Kagan, Krathwohl, et al., 1967). In stimulated recall the researcher uses retrospective accounts of the participants to examine the meanings they have for rule-conforming behaviors. Although participants are not assumed to be overtly aware of the rules they use in conversing, their observations of their own behavior
may provide the researcher with additional insights for developing categories.

Second, participant observation would allow the researcher to observe speech as it influences relationships over time in a variety of settings. Although the participant observer cannot analyze microscopic patterns of language-use, she/he can observe the relation of talk to larger forms of behavior.

Third, the use of computer simulation to test rule systems seems potentially valuable. As social rules for talk are more clearly understood, they should allow researchers to program computers to participate in conversations. If the rules are correct and complete, persons who "talk" with a computer should be able to judge the utility of the rules.

Fourth, computer analysis of discourse has proved to be highly valuable in determining structural patterns and regularities in discourse (Rush, Pepinsky, et al., 1974). As social rules become more refined through descriptive approaches, computer analysis will allow for the analysis of large amounts of data.

The preceding suggestions represent only a few ways in which rules of discourse can be examined. The reader can undoubtedly generate many additional questions and approaches. The results of this study and the conclusions about the method of discourse analysis can only be
considered valid to the extent that they are supported by other approaches.

Retrospect

This chapter summarizes the present study, describing a perspective for the study of language-use as rule-conforming behavior. It presents the argument that although discourse analysis is a primitive method, much can be learned about the organization of social talk through careful description.

The final portion of the chapter poses several questions for future research and suggests alternative methods which may complement discourse analysis.
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