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CONVERSATIONAL ANALYSIS: AN ETHNOMETHODOLOGICAL APPROACH TO THE STUDY OF CLINICAL INSTRUCTION

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

By
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* * * * *

The Ohio State University
1977

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CHAPTER I

A NATURAL HISTORY APPROACH TO THE STUDY
OF CLINICAL INSTRUCTION

Introduction

This investigation begins with the question: "How do medical dietetic students, their clinical instructors, preceptors and patients conduct clinical instruction?" The focus is on the structure of verbal interactions between and among these four critical participants in the clinical instruction process. Therefore, the major objective of this study is to record, transcribe, analyze and interpret clinical instruction interactions for the purpose of explaining and understanding the clinical instruction process. Specifically this will be accomplished through the identification of the conversational characteristics of clinical instruction and the generation of hypotheses concerning clinical instruction.

The second concern is with a specific ethnomethodological approach to the study of such social phenomena—conversational analysis. Conversational analysis, the primary analytical technique of ethnomethodology, is a system used
to examine the structure rather than the content of naturally occurring talk. Since conversational analysis has a relatively short history, the appropriateness of the technique to a variety of issues and settings needs to be determined before conversational analysis can have widespread use. Therefore, the second objective of this study is to determine the appropriateness of conversational analysis to study the substantive issue of clinical instruction as it naturally occurs. The appropriateness of the method will be conveyed through the identification of the conversational characteristics of clinical instruction and the generation of hypotheses related to that phenomenon.

This chapter focuses on several factors critical to understanding the need for the study as well as those factors underlying the study design.

**The Need**

The two factors which have precipitated this study are:

1. the existing theories and models of clinical instruction.
2. the function and limitations of the existing theories and models of clinical instruction.

**Theories and Models of Clinical Instruction**

A professional is an individual who simultaneously deals with knowledge (science) and skill (art). Health
science professions deal with the issue of knowledge and skill through an educational strategy commonly referred to as clinical instruction, clinical practice, clerkships, or practicum. Clinical instruction in the formal education of professionals is referred to as; clerkships in the education of physicians (Stritter, 1975) and clinical instruction in the education of medical dietitians (Hart, 1973) and nurses (Wiedenback, 1969).

Regardless of name, clinical instruction remains an integral component of the education of many professionals thereby stimulating the development of many theories, models and paradigms to explain and describe this phenomena. One such model has been developed for medical education (Bryne and Long, 1973) and has been applied to coordinated medical dietetic education (Unklesbay and Spear, 1975). This model divides clinical instruction into five stages. The stages are arranged in a stair step configuration indicating the continuum of didactic theory to practical reality (Illustration 1).

Order of Stages:
1. Initial exposure and observation
2. Planning practicum experiences
3. Familiarization and review
4. Supervised involvement
5. Final review and evaluation

Illustration 1
Attachment Learning Model
The actions of each participant are prescribed at each stage of the model's application to clinical instruction in medical dietetics (Unklesbay and Spear, 1975). The step-by-step movement through this model, according to its proponents, will enable the graduating student to enter professional practice with confidence and likelihood of success.

Nursing educators have also developed models of clinical instruction. One such model is based on the basic psychological theory of stimulus-response, and is called Prescription for Clinical Instruction (Wiedenback, 1969). The model schematically illustrates how a stimulus originating from within the realities of the clinical situation is transformed into an impulse that produces a deliberate action on the part of the student. This theory proposes a causal relationship between the instructor's central purpose, the prescriptive action taken, and the probable effect of this action on the student. Wiedenback (1969) states:

Prescription in clinical teaching parallels prescription in medicine in many ways. In medicine prescription signifies not only substances that are to be combined to form a particular medication, but also how the medication is to be used in order to effect the changes that the physician hopes to bring about in the patient. Similarly, in clinical teaching, prescription indicates the factors that, when combined, give direction to the instructor's action as well as to the thinking process that hopefully will lead to the results desired by the instructor (p. 11).

These models, and other models of clinical instruction (Chapman, 1975), (DeMers, et al., 1975), (King, 1971) and
(Jensen, et al., 1952), describe and prescribe the ideal learning process and the components of this process. Although much effort has been expended in formulating such models, they have not provided guidance in coping with the complexity of problems associated with the pedagogical strategy of clinical instruction. Such models have provided little aid in determining how students learn or how and what should be evaluated (Wood, 1973), (Tower and Vosburg, 1976). Nor do they advance the issue of establishing recommendations for "good" clinical instruction (Pearson, 1975).

Functions of Theory

Glaser and Strauss (1967) have attempted to explain the basis for the shortcomings of logico-deductive models or theories, of which clinical instruction models are examples. Although Glaser and Strauss were specifically speaking of sociological theory, their comments are relevant to theorizing in general. In addition, clinical instruction is, by definition, a social phenomena. That is, clinical instruction is a meaningful human action.

Glaser and Strauss maintain the position that theories, models or paradigms should serve five interrelated purposes:

1. To enable prediction and explanation of behavior.
2. To be useful in theoretical advances.
3. To be useful in practical applications (prediction and explanation should be able to give the
practitioner understanding and some control of situations).

4. To provide a perspective on behavior.

5. To guide and provide a style for research. (p. 3)

Limitations of Existing Theory

To develop theories, models and paradigms that fulfill these five purposes requires systematic discovery from data of social research. That is, the empirical study of the social phenomena to provide data from which theory can be generated. By contrast, the source for some theories, models and paradigms has been something other than data. Often this non-data source has been logical deduction based on assumptions. This can result in data being made to fit the theory rather than the theory fit the data. Logically deduced theory lives apart from reality and does not necessarily fulfill the purposes of theory.

Models, theories and paradigms in clinical instruction, of which Attachment Learning and Prescription of Clinical Teaching are samples, are logically deduced and not based on empirical evidence. Therefore, as Glaser and Strauss have stated, these theories are of little aid in understanding, explaining and predicting reality or guiding research. Thus, the problem facing clinical instruction theorists is that the models, theories and paradigms of clinical instruction simply do not describe or explain the reality of clinical
Since the hypothetical research method has been used almost exclusively in investigating social phenomena, models and theories have been developed via logical deduction. Social phenomena research has attempted to keep pace with physical phenomena research (Speier, 1973) despite its relatively short history. As far back as 1665, with the study of cork and other tissue by Robert Hooke, physical science established a model of investigation beginning with systematic empirical study of the phenomena preceding theorizing. It was only after empirical study that the hypothetical research method was employed by physical scientists. Subsequently, the hypothetical method attracted investigators of social phenomena. However, social science does not have the history of inductive study that physical science has. The result has been the development of hypotheses, theories, models and paradigms based on little or no empirical evidence.

Therefore, Speier (1973) urges an investigative orientation that is closer to that of early biological science. Speier, however, was not the first to suggest this approach. Seventy-five years ago Durkheim, a noted sociologist, pointed out that science ought to proceed from things to ideas not from ideas to things.

Although the position Glaser and Strauss (1967) take is that there is no fundamental clash between the purpose and
capacities of qualitative and quantitative methods or data, they give strong support to qualitative methods of investigation as a way of proceeding from things to ideas. Similarly, Speier's (1973) natural history approach focuses on empirical observation. This is the same method Hooke used, while spending endless hours looking at tissue; and the same method Mendel used while studying the inheritance of plant characteristics. Both of these early investigators realized the crucial importance of systematic data collection of the phenomena of interest as it naturally occurs.

Ethnomethodology

Ethnomethodology, which began with the work of Harold Garfinkel (Mullins, 1973) in the mid 1950's, can be described as qualitative in nature. Turner (1974) states that ethnomethodology takes a field research position in which observation is basic. Ethnomethodology, also called a natural history approach (Speier, 1973), understanding everyday life (Douglas, 1973), and common understanding (Garfinkel, 1964), has as its prime concern, the study of social phenomena as it ordinarily occurs in reality (Schatzman and Strauss, 1973). This approach presupposes that any scientific understanding of human action, regardless of ordering or generality, must begin with, and be built upon an understanding of everyday life of the members performing those actions. The following is a discussion of
the seven major conceptual components of ethnomethodology.

First, the investigator utilizing ethnomethodology, proceeds from a theoretically non-structured position. That is to say, the investigator does not enter the research arena with a preconceived, conceptual framework pertaining to the motives, means, condition, or ends of the social conduct. Encouraged by Kuhn's, *The Structure of Scientific Revolution* (1962) which recognizes the historicity of scientific paradigms, investigators have addressed themselves to (1) the reflexivity of human thought and action, and (2) the importance of the interpretive factors in human behavior. Parenthetically, **reflexivity** refers to the fact that participants of interaction are simultaneously involved in understanding or making meaning out of what is happening and also making it happen.

Secondly the investigator focuses on the emic rather than the etic approach to interaction. Michael Watson (1972) has explained these two points of view:

The etic point of view approaches a system of behavior from outside the system, using criteria which are external to the system.... (It) provides an initial base from which the observer can begin his analysis of the system. Statements made about the system in etic terms depend on phenomenal distinctions judged appropriate by the community of scientific observers. The emic approach...is concerned with studying behavior from inside a single, culturally specific system. Criteria used in an emic description are drawn from the contrasts made within the system itself and are relevant in
terms of the internal functioning of the system. Emic distinctions are those which are recognized as meaningful to the interactants who 'use' the system. (p. 3)

Third, once adequate emic descriptions or first order constructs have been achieved, only then can second order concepts or social scientific constructs be formulated. This move from the common sense level to the theoretical scientific level has been called "transformation" by Schutz (1953).

Fourth, this perspective assumes that the social world is always interpreted. Therefore, the primary task of the researcher is to determine, as precisely as possible, the actual methods or systems of interpretation used by the social actors in a given social situation. (Hinkle et al., 1973).

Fifth, where others might see things as facts of life, the ethnomethodologists sees process. This is the process through which the perceived stable features of the socially organized environment are continually created and sustained (Pollner, 1974).

Sixth, the investigation is never in a 'laboratory' setting. The researcher makes every attempt to study events of interaction as they naturally occur. This means avoiding interventions, of any type, in the traditional experimental sense. This circumvents the concerns raised by researchers, such as Rosenthal (1966), regarding the transferability of
results from experimental settings to natural settings.

Last, the investigator takes a wholistic or Gestalt approach to interaction. Not only do the actors give meaning to the interaction, but the context provides meaning as well. What has transpired provides means to what follows and vis versa. That is, each action is understood by the participants in terms of the place of the action in the context of what has gone before and what they see as the future course of interaction. Sacks (1966) refers to this characteristic of interaction as the "indexical particular."

In summary, ethnomethodology is a relative new research tradition which assumes the position that social phenomena must be studied as it naturally occurs. Ethnomethodologists realize that the entire social context gives meaning to interaction and, therefore, is a vital component of any social research. Conversational analysis, which is the primary analytical technique in ethnomethodology, will be the topic of an extensive discussion in Chapter II.

**The Problem**

Since clinical instruction is a vital educational strategy for many health science professions, theories, models and paradigms have been developed to guide and direct practitioners of clinical instruction. The prime method used to theorize has been a deductive and speculative process. As a result, these theories, models and paradigms are
inadequate because they are not based on the reality of the context in which clinical instruction occurs. The problem, then, is that theory does not fit reality because it is not based on systematic observation of clinical instruction before theorizing.

**Purpose**

This study takes the position that the social phenomena of clinical instruction can be observed in such a way that data so generated can be described with an increasing degree of detail. In order to understand and explain clinical instruction, empirical study of that phenomena as it naturally occurs is imperative. This position has been labeled a qualitative approach because it describes rather than measures.

This study will begin the first step in a long journey of coming to know, understand, predict and control the phenomena known as clinical instruction. That step is the systematic observation of clinical instruction for the dual purpose of (1) identifying the structural characteristics of clinical instruction and generating hypotheses, and (2) determining the appropriateness of conversational analysis to investigate such a phenomena.
Clinical Instruction

Although clinical instruction activities may be known by many different names, for the purpose of this study, the term "clinical instruction" will be used exclusively. In addition, the focus of this study will be the application of clinical instruction in the professional education of medical dietitians.

Theoretical Basis of Clinical Instruction

Historically, clinical instruction in the form of apprenticeship is one of the oldest teaching methods known to man. As more structure was placed on such teaching-learning arrangements, the term clinical instruction came into use.

At the outset, clinical instruction was undoubtedly used for lack of any other method of instruction. However, as the pool of psychological and pedagogical principles enlarged, clinical instruction, as a method of instruction, aptly fit these emerging principles. Today, the use of clinical instruction, as an educational strategy, is predicated on two major, fundamental psychological principles—transference (Humphreys, 1951), and role modeling (Saupe, 1961).

"Transference" refers to the extent to which knowledge and skills learned in one situation are applied to new and different situations. Applied to clinical instruction,
transference means that the more similar the learning situation is to the real situation, the more likely the learned knowledge and skills will be transferred to the real situation (de Törngay, 1971). This assumes, of course, that the student recognizes the similarity between the learning situation and the real situation.

Role modeling or identification has been a prominent notion in theories of socialization. In its simplest terms, identification is a process in which the individual takes on the behavior pattern of another significant individual and behaves as if he were that individual (Hamachek, 1971). A related notion supported by some studies (Hobbs, 1966; Krasner and Ullmann, 1965; Wolpe, 1958; and Hastorf, 1965) suggests that a behavioral pattern can be changed without an individual's prior awareness or insight. A more interesting aspect of these studies seems to indicate that change in at least some kinds of behavior can occur without insight, but also, that insight or attitude change may subsequently follow (Festinger, 1957).

As applied to clinical instruction, "role modeling" or identification suggests that students view the competent professional and are given the opportunity to pattern their own behavior on that of the professionals'. Mager (1968) points out that the modeling or identification process can be most important in the student's acquisition of attitudinal objectives.
Definition of Clinical Instruction

Clinical instruction has been described as an educational process which involves a one-to-one relationship between a student and an instructor-professional within the professional environment (American Dietetic Association, 1974). Crucial to this process is the integration of cognitive learning and practical experience. Clinical instruction can be described as a process by which students develop their potential for safe, effective, competent functioning within the realities of their immediate clinical situation. It is an extension of academic learning, in that, academic learning enables the student to assimilate, understand and store essentials of subject matter. Clinical instruction extends academic learning by enabling the student to translate learned subject matter into practical knowledge and to apply it meaningfully in the clinical environment (Wiendenback, 1969). Similarly, Reddout (1973) defines clinical instruction as guided reality experiences which are correlated with theoretical or didactic learning to provide opportunities for the application of learning and acquisition of skills.

Components of Clinical Instruction

The operational components of clinical instruction central to this investigation are the environment and the participants. The environment will be defined as either
a life-like or simulated situation in which the competent professional ordinarily functions. Although medical dietitians may function in a variety of environments, the environments cogent to this study are (1) the hospital, and (2) the clinical instructor's office.

The participants of clinical instruction may be classified into three groups: (1) learners or students, (2) teachers or instructors and preceptors, and (3) recipients or hospitalized patients. The students or learners are individuals who are acquiring or have acquired knowledge and skills related to professional performance. The goal of these individuals is to become a competent professional by providing service to recipients. Learners in this study are medical dietetic students who are concurrently acquiring didactic knowledge and clinical skills. During the process of clinical instruction, students are given the opportunity to (1) acquire further knowledge and skills, (2) apply acquired knowledge and skills as the clinical environment demands, and (3) demonstrate acquisition of knowledge and skills through their performance in the clinical environment.

The teachers, or instructors and preceptors are individuals who guide and facilitate the learner's, (1) application of knowledge, (2) acquisition of skills, and (3) generalization beyond the clinical environment. These individuals have two major responsibilities, (1) insure the safety of
the patient, and (2) facilitate the learners' acquisition and application of knowledge and skills. Although this function may be fulfilled by a single individual, in the context of this study, two groups of individuals functioned in this manner. One group, referred to in this document as instructors, are academic faculty who participate in the didactic as well as the practical education of the learner. The prime function of this group of individuals is to plan, coordinate, monitor and evaluate didactic and clinical learning. This group of individuals, while only indirectly responsible for service to the recipients, are directly responsible for the safety of the recipient through the learner's performance.

The second group of individuals, referred to as preceptors, are practitioners who participate in clinical instruction activities. This group is directly responsible for professional service to all recipients whether learner-provided or practitioner-provided. In relation to the learner, this group of individuals functioned as a resource for (1) knowledge concerning the recipient, and (2) knowledge concerning the practical aspects of providing professional service to recipients.

The last group of individuals participating in clinical instruction are recipients of professional service or hospitalized patients. Since all recipients in this study were hospitalized patients, the term "patient" will be used to
describe the recipient. The patient is the individual in whose behalf professional action is taken. The agent of this professional action is the learner under the direction of the instructor and/or the preceptor.

The term "professional action" refers to the activities of the learner, instructor, or preceptor in providing nutritional care to the patient. Providing nutritional care to recipients is central to the profession of dietetics. The Study Commission on Dietetics (1972) defined dietitians and their professional activities in the following manner:

The dietitian is a "translator" of the science of nutrition into the skill of furnishing optimal nourishment to people. The word "translator" is used in its familiar context of "translating ideas into action". This concept starts with the same beginning point (the science of nutrition) and arrives at the same end point (the optimal nourishment of people) no matter what the particular role of the dietitian or the purpose of his employing institution may be. (p. 3)

Techniques for the Study of Talk

The characteristic of clinical instruction which serves as the focus of this study is the occurrence of interaction. Interaction, which occurs among all participants in the clinical instruction environment, has traditionally been divided into verbal and nonverbal interaction. This study, however, will focus on face-to-face verbal interaction only. Nonverbal interaction remains beyond the scope of this study. Limitations which prohibit investigation of
nonverbal interaction will be subsequently discussed in Chapter III. According to Speier (1973), rigorous analysis of verbal interaction is possible because of the shared knowledge (within a culture) of standard speech notation. In fact, much of what is understood by participants in a social environment is communicated and perhaps even structured through talk.

There exists a number of traditions of investigation which contribute to the study of face-to-face interaction. The remainder of this section will be devoted to a discussion of each of these methods of investigation along with the reasons these methods were not appropriate for this study. In addition, the analysis method of choice, conversational analysis, will be discussed.

Role Analysis

Role analysis, one tradition focusing on face-to-face interaction, has its roots in symbolic interactionism (Mead, 1934) and anthropological role analysis (Linton, 1936). The purpose of this method of study has been to explain individual behavior by association with institutionalized role expectations which demonstrate themselves in interaction. The interests of investigators using role analysis have included attitudes toward self, role-taking ability, definition of the situation, organization of roles into systems, the relationship of individual personality to social expectations
and a situated and role-governed view (as opposed to a psychodynamic view) of individual action (Schegloff, 1967).

As the list of investigator's interests indicate, interaction is part of the analytic strategy of role analysis and not the prime focus of the analysis. Schegloff (1967) points out that the main import of this tradition for the study of face-to-face interaction has been clarification of the situated character of individual behavior. However, it does not elucidate the details of those situations. Role analysis, therefore, fails to provide an appropriate strategy for this study since it does not provide adequate tools for detailed empirical study of face-to-face verbal interaction.

Social Systems Analysis

A second method employed to study interaction is social systems analysis. Social systems analysis, unlike role analysis, does attempt to specifically deal with interaction. Particularly, the social system analysis inquiry technique of Bales (1951) describes details concerning interaction in problem solving groups as influenced by problems intrinsic to small groups in social systems. Although this technique does investigate interaction per se, it does not assume the same point of view of interaction, as this study. Specifically, social systems analysis is not an appropriate method of analysis for the following reasons
1. Although interaction is the focus of Bales' analysis process, the interest in talk is related to theoretical problems which are not specific to interaction.

2. Bales' analysis process requires coding of talk into a number of specific categories (such as "giving instructions"). Although there is a serious attempt to achieve inter-coder reliability of interaction coding, there is no attempt to identify the intuitive mechanisms which permits such judgements.

3. Lastly, the approach to interaction as exemplified by Bales, is experimental in nature. The research of Rosenthal (1966) has seriously challenged the transferability of findings from experiments to non-experimental settings.

**Interactional Analysis**

A third tradition used to investigate face-to-face interaction is called the Observational System for Instructional Analysis (OSIA) which was developed by Hough and Duncan (1970). This technique for analyzing interaction was developed primarily to describe and analyze instructional strategies and tactics in an educational environment. Like the Bales analysis technique, OSIA codes interaction; but
unlike the Bales technique, both verbal and nonverbal instructional events are classified. Coded behaviors are then accumulated, summarized and displayed on a graph-like matrix.

Although interaction per se is the focus of this analysis process, it does not assume the same view of interaction as this study for the following reasons:

1. Although interaction is investigated, the interest in talk is related to quantification of talk and the identification of certain instructional tactics (Speier, 1970).

2. Like the Bales analysis process, OSIA requires coding of verbal and nonverbal behavior into a number of categories. While there is concern for inter-coder reliability in coding judgements, there is no concern for the mechanism which makes this judgement possible.

**Linguistic Analysis**

Linguistics is still another tradition concerned with talk. However, linguists have, as their focus, the study of the structural interrelationships of various components in linguistics. The unit of study has almost always been the sentence as in studies of grammar and syntax. While linguistic analysis demands the use of the sentence as a unit of study, there is nothing to suggest that the sentence is
a crucial or relevant unit for the study of interaction (Shegloff, 1967). In fact, use of such a unit seems to interfere with the utility of linguistic analysis for understanding face-to-face interaction. Thus, linguistic analysis is not an appropriate tool for investigating interaction in this study.

**Game Theory**

Another tradition used to investigate interaction, which will be discussed here, is game theory. Game theory attempts to specify the parameters of rational decision making under situations varying in information and complexity (Von Newmann and Morgenstern, 1964). This method of analysis, however, is not appropriate for this study because the prime concern of game theory is to provide a model which might illuminate some aspects of observable interactional episodes, not the empirical study of interaction (Schegloff, 1967).

Since the traditions discussed above are not appropriate, what tradition does empirically observe interaction in the manner which is consistent with the arguments of Glaser and Strauss (1967) and Speier (1973) discussed earlier in this document? The tradition of conversational analysis, the primary technique of ethnomethodology, is suited to these parameters and will be discussed in the following section.
Conversational Analysis

Although conversational analysis is the technique of choice, like other traditions investigating social phenomena, it has limitations. The nature of the method itself is both a strength and a limitation. Traditional experimenters, by stating the variables they will investigate, imply what they will not investigate. In so doing, the ethnomethodologist believes, that they neglect crucial, yet unexpected nuances of social phenomena. The ethnomethodologist, on the other hand, do not state what they will or will not study, only where they will begin. This intuitive nature of conversational analysis, a strength, is also a limitation in that it has prevented ethnomethodologist from attempting to identify procedures for deriving results, even retrospectively. There are three other categories of limitations of conversational analysis, (1) data collection procedures, (2) data analysis procedures, and (3) interpretation procedures.

The limitations of data collection and analysis procedures are related to the lack of attention to criteria development for these procedures. Only recently have attempts been made to identify (1) criteria for making observations, and (2) criteria for analyzing observations. Other limitations of data collection involve technical problems of recording verbal interaction via cassette tape recorders and the intrusion such recordings make in the phenomenon being
investigated. The requirement of formal consent of subjects prior to participation in this study also resulted in data collections limitations and ultimately limitations in analysis and interpretation. Other limitations of analysis procedures involve the absence of a system to identify the appropriate procedural steps of analysis for a particular investigation.

The limitations of the interpretation procedures are related to the methodological problems of validity and reliability. These problems are not unique to ethnomethodology and conversational analysis but do require special attention because of the embryonic developmental stage of the methodology and the analysis technique.

**Summary**

Clinical instruction, an educational strategy widely used in professional curricula, has received much theoretical attention. However, scholars of this strategy have assumed a deductive position. This has resulted in many different notions of clinical instruction, none of which has been entirely useful in understanding or conducting clinical instruction.

This study proposes to take an inductive, qualitative research position in the investigation of clinical instruction, as suggested by Speier, Glaser and Strauss. Evidence suggests that ethnomethodology, specifically conversational
analysis, is well suited to the empirical observation of clinical instruction in order to explain and understand this phenomenon—the "doing" of clinical instruction. The explanation and understanding of the accomplishment of clinical instruction will then be conveyed through (1) the identification of the conversational structural characteristics of clinical instruction, and (2) the generation of hypotheses concerning clinical instruction. An additional purpose is to determine the appropriateness of applying conversational analysis to investigate substantive issues in disciplines such as medical dietetics. This will also be conveyed through (1) the identification of the conversational structural characteristics of clinical instruction, and (2) the generation of hypothesis concerning clinical instruction.
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CHAPTER II

REVIEW OF LITERATURE

Introduction

The focus of the first section of Chapter II is a review of the literature reflecting the development of ethnomethodology. This was judged necessary because ethnomethodology and its primary analytical technique, conversational analysis, are in the developmental stage. The second section is devoted to the issues generated by ethnomethodology and, specifically, conversational analysis. The third and final section discusses ethnomethodological research using conversational analysis as well as other ethnomethodological techniques.

Historical Perspective of Ethnomethodology

Nicholas Mullins (1973) has divided the history of ethnomethodology into four stages. A description of these four stages helps to understand some of the problems facing ethnomethodologists and those employing conversational analysis.
The Normal Stage: to 1957

The term "ethnomethodology" was coined by Garfinkel (Hill and Crittenden, 1968) to emphasize the position that ordinary, naturally occurring human behavior is an appropriate topic for social science investigation. The word derivation of ethnomethodology, itself, reflects this belief. "Ethno" means folk knowledge as opposed to professional, scientific knowledge.

Hence, ethnomethodology is the study of the methods used by members of a group for understanding communication, making decisions, being rational, accounting for action, and so on. (Mullins, 1973, p. 184).

Much of the early ethnomethodological development is tied to Garfinkel's professional relationships and places of study. While Garfinkel was still a doctoral candidate at Princeton, he studied with Alfred Schutz at the New School of Social Research in New York. While between jobs, in 1954, he was temporarily hired by the University of Chicago Law School to study juries through analyzing tape recordings of jury deliberations. While at UCLA, Garfinkel's interest in the jury studies continued with particular attention to the question of how jurors "knew what they were doing in doing the work of jurors" (Hill and Crittenden, 1968).

This concern with the procedures and methods of rationality among the jurors came to typify empirical research in ethnomethodology (Mullins, 1973, p. 185).
The intellectual content of ethnomethodology comes from a variety of disciplines. However, one of the most influential sources was the social philosopher, Alfred Schutz. Schutz's philosophy was based on Husserl's (1913) phenomenological position that each person has a "natural attitude" of everyday life which he takes toward the world. Schutz amplified this perspective in his published works on:

1. The dimensions of the social world.
   a. social reality within the reach of direct experience.
   b. the world of contemporaries as a structure of typifications.
   c. the world of predecessors and problems of history.

2. The problem of rationality in the social world.


Although Schutz's ideas were necessary to the emergence of ethnomethodology, they were not sufficient. Strict phenomenologists, such as Aron Gurwitsch (1966), and linguistic philosophers, such as John Austin (1962) also contributed to the process. In addition, generative linguists, such as Chemsky (1968), and cognitive anthropologists, such as Dell Hymes and Harold Conklin were most influential because of the focus of their disciplines.
Although such philosophies clearly influenced methodological development, it was not until 1956 that Garfinkel (1956) published a program statement for ethnomethodology. However, this statement was limited in nature, in that, it identified only short-range goals, rather than long-range comprehensive goals. Subsequent stages of ethnomethodological development also reflect this limitation.

The Network Stage: 1957 - 1966

The most prominent feature of the network stage was the organization of two seminar groups concerned with ethnomethodology. One group, which included Bittner, McHugh and Cicourel, was located at UCLA under the leadership of Harold Garfinkel (Mullins, 1973). The second group, led by Harvey Sacks, which discussed the work of Garfinkel and Cicourel, was located at Berkeley (Sudnow, 1971).

Although study groups of students were forming, ethnomethodology was still slow to develop. This was partly because, as yet, little had been published, and because neither UCLA or Berkeley had large, graduate sociology programs.

By 1964, the reputations of Garfinkel and Cicourel had spread with the publication of Method and Measurement in Sociology by Cicourel (1964), Educational Decision Makers by Cicourel and Kitsuse (1963), and by several articles by Garfinkel (1960, 1962, 1963).
In 1965, Cicourel arrived at Berkeley and became the leader of the group of students organized by Sacks. These students included Jefferson, Moorman, Schegloff, Speier, Sudnow and Turner, who subsequently became proponents and researchers in ethnomethodology.

During the network stage the Collected Papers of Alfred Schutz were published which provided a background against which ethnomethodology could be discussed. Much of the research conducted during this phase was not published until the 1970's. Consequently, sociology, at large, was unaware of the strides in ethnomethodology for approximately a decade.

It was during this phase that the fundamental differences between structural functionalism and ethnomethodology became apparent. Structural functionalism is based on the assumption that there exists a stable system of symbols whose meanings are shared by all members of society. Ethnomethodology, on the other hand, questions whether meanings are shared. Furthermore, ethnomethodologists focus on the question of how respondents know what is expected of them and how behavior or responses are selected from the many possibilities.

Thus, the focus is not on activity, but rather on the process by which members manage to produce and sustain a sense of social structure. (Mullins, 1973, p. 195)
Ethnomethodology's research question and rejection of structural functionalism constituted a radical break from standard American sociology.

It was during this phase (Mullins, 1973) that ethnomethodology began to define its field of study as:

1. the acquisition of socially distributed cultural knowledge.
2. cultural knowledge, occasional invocation and use in interaction encounters.
3. the process by which other members of society judge specific social behaviors as acceptable displays.

The Cluster Stage: 1966 - 1971

During the cluster stage, ethnomethodology continued to develop at three Western institutions:

1. UCLA, under the leadership of H. Garfinkel
2. Santa Barbara, under the leadership of A. Cicourel
3. University of California at Irvine, under the leadership of H. Sacks.

During this stage, Garfinkel published Studies in Ethnomethodology (1967), and Cicourel began to interest graduate students in using ethnomethodology in their research studies. In addition, the published work of Sacks and Schegloff was being noted by linguists and anthropologists.
The cluster stage was fertile with publications of ethnomethodological research by Sudnow (1967), Garfinkel (1967), Cicourel (1968), McHugh (1968), and McAndrew and Edgerton (1969). Other research conducted after 1967, such as studies by Zimmerman and Pollner (1970), and Wilson (1970), were based on new program statements by Garfinkel (1967).

Although ethnomethodologists were publishing, Mullins (1973) hastens to point out that it was by no means easily accomplished in traditional journals of American sociology. Therefore, to distribute their work, ethnomethodologists began to mimeograph their papers and distribute them privately. By 1971, such distribution lists included disciplines outside the original theory-building groups. This resulted in non-sociologists adopting ethnomethodology and ethnomethodological research.

The Specialty Stage: 1971 -

The beginning of the specialty stage was marked by the movement of ethnomethodologists to many other university campuses in the East as well as the West. This movement greatly fostered an East-West split in tactics of analysis. The East coast group, exemplified by McHugh (1968), Blum and McHugh (1971), focused on talk about analysis rather than actual research data and analysis. On the West coast a further split developed between conversational analysis
(Sacks, 1973 and Schegloff, 1968) and language acquisition and rule-using analysis (Cicourel, et al., 1974).

These differences in tactics became more apparent as a movement began, in 1972, to change the name of ethnomethodology. Although this movement has died, some basic differences remain.

Problems Associated With Conversational Analysis

There are three major problems associated with conversational analysis. These problems result in (1) limitations in investigations using conversational analysis, and (2) difficulty for students learning to apply ethnomethodology and conversational analysis.

The first problem is the scarcity of published research using conversational analysis which discusses procedural steps taken to get results. Most often, published studies present formal descriptions of results based on the intuitions of the researcher and supported by evidence selected from transcriptions.

Nofsinger (1973) argues that use of intuitive judgement is based on the assumption that the investigator possesses the competence essential to interpret the actions of members of the same language community. Litton-Hawes (1976) states that, for the conversational analysts, talk is both the subject and the source of the study. While the investigators cannot eliminate their cultural knowledge of the subject
matter, they are obligated to create an analytical account which is not unique only to their own intuition. According to Turner (1974) the problem is unavoidable.

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).

Although the importance of intuition as a foundation for phenomenological knowledge is granted, the intuitive approach does not lend itself to articulation in advance. While it is evident why ethnomethodologists cannot know the route their analysis will take in advance, their studies should, in retrospect, discuss the procedures they found useful. This would provide some direction to others attempting ethnomethodological research.

The second problem involves criteria for judging the validity and reliability of conversational research. Speier (1973) makes the point that since conversational analysis is in its developmental stage, such criteria have yet to be delineated.

Litton-Hawes (1976), however, has made an initial attempt to identify (1) criteria for making observations, and (2) criteria for interpretation of data:
Criteria for making observations:
1. Specify the conditions under which data is obtained.
2. Provide relevant information about the nature of the sample (participants).

Criteria for interpretation of data:
1. Demonstrate that findings are consistent with the data.
2. Findings must be internally coherent.
3. Findings should demonstrate a capacity to explain related theory.
4. If findings account for the data, they should help account for and anticipate similar behaviors under similar circumstances.
5. A balance must be maintained between subjective and objective interpretation.
6. Findings must be clear and detailed to allow for verification of findings.
7. A standard of heuristic value must be applied to research. (pp. 38-43)

The third problem involves the means by which the findings or results are made evidential. In other words, ethnomethodologists are asked to justify the manner in which qualitative researchers support their findings. Litton-Hawes (1976) points out that both the quantitative and qualitative researchers have similar problems of
evidentiality in the following ways:

1. The quantitative researcher uses statistics as a measure of central tendency to summarize and interpret data. The conversational analysts employs structure or rules to describe the central tendency of data.

2. The quantitative researcher infers a causal relationship between independent and dependent variables. While rejecting causal explanation, the conversational analyst uses more sensitive, intentional explanations.

3. The problem of evidentiality for the quantitative researcher, stated concise, is, Does the way in which the observations were made satisfy the statistical assumptions. The problem for the conversational analysts is, Do the observations satisfy the presuppositions for the structures or rules, and the logical entailments of the rules.

In essence, the question is one of suitability for both researchers. Litton-Hawes' (1976) comments regarding evidentiality are most salient.

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 that 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 too 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. (pp. 36-37)

In summary, this section has identified the major problems facing those researchers employing conversational analysis. Some problems are unique to qualitative researchers; others are not unlike problems facing all researchers regardless of qualitative or quantitative focus.

Related Research

This section attempts to present prominent studies in ethnomethodology. Many of these studies employ conversational analysis as the analytical technique, others do not. The first part of this section deals with the five features of reality (Mehan and Wood, 1975). The second part of this section presents studies which illustrate a linguistic's approach to conversational analysis. The third part discusses studies which are related to the west-coast theory group's focus of language acquisition and rule-using
Features of Reality

Mehan and Wood (1975) define ethnomethodology as a reality that investigates the common features of all realities. Accordingly, ethnomethodology and other realities are dependent on (1) reflexive use of, (2) bodies of social knowledge in, (3) interaction. Since reality is sustained by reflexive interactional work, it is (4) fragile, and (5) permeable to other realities. The remainder of this section will be devoted to elaborating these five features.

Reality as Reflexive

There exists in each culture or reality a number of axioms or absolutes. Gasking (1955) called them "incorrigible propositions." According to Evan-Pritchard (1937), such axioms exist in the Azande culture of Africa which Western culture would probably call superstitions. Whether they are called axioms, principles or superstitions,

An incorrigible position is one which you would never admit to be false whatever happens: it therefore, does not tell you what happens...The truth of an incorrigible position...is compatible with any and every conceivable state of affairs. (For example, whatever is your experience on counting, it is still true that \(7 + 5 = 12\).) (Gasking, 1955, p. 432)

If the superstition does not work for the Azande, a taboo was breached or a witch interfered. If \(7 + 5\) does not equal 12, there was a miscount. In other words, the
failures do not challenge the axiom, but are explained in such a way as to support it.

Beginning with an incorrigible belief in oracles (or axioms), all events reflexively become evidence for that belief. (Mehan and Wood, 1975, p. 10)

If for some reason there is a change in an incorrigible proposition, there is, at the same time, object constancy. Object constancy is the belief that objects remain constant over time and across viewing from different positions and different people. For example, when individuals were converted to Copernicanism, they did not believe that the sun changed over time, but that their perception of the sun was mistaken.

Once an alternative seeing is explained away, the accepted explanation provides evidence for that object constancy assumption that made the explanation necessary in the first place. By demanding that we dismiss one of two equally valid empirical determinations, the object constancy assumption leads to a body of work that validates that assumption. The work then justifies itself afterward, in the world it has created. This self-preservation, reflexive process is common to oracular, scientific and commonsense reasoning (Mehan and Wood, 1975, p. 12).

Garfinkel (1967a) believes that talk was well as scientific and commonsense reasoning is reflexive. That is, talk delivers information and creates a world in which that information can appear. Greetings, for example, create and maintain a world in which persons acknowledge each other, create the expectation for a return greeting, etc. When a
greeting fails, a person does not return a greeting, one does not say that the greeting was not "real", but uses the situation to reflexively reaffirm the reality of the greeting. This is done by saying, "She did not hear." Therefore, talk illustrates the same reflexive process as axioms, scientific reasoning or Azande superstitions.

**Reality as a Coherent Body of Knowledge**

Chomsky (1965), a linguist, found that within language-using communities, there exists rules of grammar. Although investigators can empirically establish the grammatical rules, the speakers and hearers are unable to list them, and in fact, are unaware rules even exist. In essence, all realities upon analysis exhibit a coherent system of knowledge, but the knowledge of this coherence is not necessarily known by the participants of the reality.

On the surface this feature may seem problematic for the ethnomethodologist. However, it must be made clear that the coherence feature, like all features of reality, operates as an incorrigible proposition which is reflexively maintained. Mehan and Wood state,

Features emerging "upon analysis" is a particular instance of reflexively. These features exist only within the reflexive work of those researchers who make them exist. This does not deny their reality. There is no need to pursue the chimera of a presuppositionless inquiry. Because all realities are ultimately superstitious, the reflexive location of reflexivity is not a problem within ethnomethodological studies. Rather, it provides
them with their most intriguing phenomenon.
(p. 19)

**Reality as an Interactional Activity**

This feature can be best illustrated by Wood's (1968) work with labeling in psychiatry wards. Wood devised a systematic taxonomy of patient labels based on four nursing problems. He then followed a number of patients and discovered that the labels given the patients were subject to change. More importantly, labels and label changes were dependent on the social interactional context. When labels changed, the behavior of the psychiatry attendents toward the patient also changed. For example, a patient's behavior of breaking a window was described, at one point, as suicide, when the label depressive was used. At another point, the same behavior was described as conning when the label sociopath was used.

Wood's study indicates that labels are not applied in accordance with correspondence principles. Instead, labels are indexical expressions. Meanings are situationally determined. They are dependent upon the concrete context in which they appear. The participants' interactional activity structured the indexical meaning of the labels used on the ward. The relationship of the participants to the object, the setting in which events occur, and the circumstances surrounding a definition, determine the meaning of labels and of objects. (Mehan and Wood, 1973, p. 23)
Fragility of Realities

Realities are fragile in that they are capable of dissolution if any one of the three previously described features is disrupted. Garfinkel (1963) has illustrated this feature in his studies called "incongruity procedures" or "breaching experiments". For example, Garfinkel had an experimenter engage a subject in a game of tick-tac-toe. The subject was asked to make the first move. The experimenter then erased the subject's symbol, put it in another box, and then placed his own symbol. The subjects were bewildered and confused.

The reality of the game, which before the experimenter's move seemed stable and external, suddenly fell apart. For a moment the subjects exhibited an "amnesia" for social structure. (Mehan and Wood, 1973, p. 24)

This feature of reality is even more evident in everyday life where the rules are not nearly as explicit as in the game of tick-tac-toe.

Permeability of Reality

The reflexive use of social knowledge is fragile and interactionally dependent, which means one can move in and out of different realities. Keep the River on Your Right (1969) is a book written by Tobias Schneebaum, a New Yorker, who traveled through the jungles of Peru. While in Peru he assumed the reality of the Akaramas, a stone age tribe, and engaged in mass murder, cannibalism and public homosexuality.
(all moral activities in the Akaramas reality).

Schneebaum eventually left the Akaramas and returned to Western reality. This autobiography, however, illustrates three conditions which appear to be necessary to successfully move from one reality to another:

1. No place to escape from the new reality.
2. No time to escape from the new reality.
3. No one to provide counter evidence to the new reality.

In summary, these five features of all reality, including ethnomethodology, are intimately interrelated. Discussions of these features will continually arise as various research studies are subsequently presented.

**Linguistic Approach to Conversational Analysis**

The first group of studies to be discussed are related to the linguistic approach, and has significant meaning for ethnomethodology, at large. One of the primary features of ethnomethodology studies, according to its philosophy, is that the event which is studied occurs naturally within the social context. The studies included in this first group, however, involve bits of talk, usually called utterances, with little or no attention given to (1) the individuals making the utterances, (2) the history preceding the utterances, (3) the subsequent utterances or (4) the social context of the utterance. Thus, these studies and those in the
next section will illustrate some of the different analytical approaches ethnomethodologists have taken.

To support the linguistic approach to the study of talk, based on the work of Austin (1961), ethnomethodologists have taken the position that talk is performance. According to Austin, performance in the form of conversational material accomplishes an act by its very utterance. For example, an individual stating, "I promise", actually accomplishes promising. Therefore, talk can be studied and analyzed as the doing of activities. Ethnomethodologists treat talk as a topic of study since they study the production of talk, not the subjects reported in the talk.

Harvey Sacks was one of the first ethnomethodologists to take a linguistic-ethnomethodological approach to the study of conversation. Sacks focused on small bits of audio recorded conversation devoid of social context. After the taped conversations were meticulously transcribed, Sacks applied an analysis method consisting of (1) displaying practices and (2) building the mechanism or rules so that the practice or phenomenon could be reproduced. Four mechanisms uncovered by this method will be discussed, (1) membership category device, (2) pared utterances, (3) turn-taking, and (4) repairs.

Sacks' (1965 - 1968, 1966, 1972) studies suggest the operation of a membership category device. A membership category device is a collection of categories which may be
employed to classify a population. For example, a membership category device may be "stage of life" which contains the categories baby, child, adolescent and adult. Another membership category device is "family" which includes the categories baby, mommy, daddy, brother, etc.

Sacks' work suggest that there are two rules which govern the application of devices—the economy rule and the consistancy rule. The economy rule states that if a category from a device can be used to categorize another in a referentially adequate way, then the device may be applied to the population being described. The consistancy rule states that if a category from a device is used to categorize a member, then the category or other categories from the same device may be used to categorize other members of the population.

An example employing this device and its rules will be helpful. In the utterances, "The baby crawls. The adolescent walks", the first word possible to categorize is "baby". This word identifies the two possible membership category devices previously mentioned—stage of life and family—since "baby" is a category in both devices. Now applying the consistancy rule, look at the second word possible to categorize—"adolescent". The consistancy rule states that, if at all possible, "baby" and "adolescent" must be of the same category device. They are both found in the stage of life category but not the family category.
Therefore, the membership category device for these utterances is stage of life.

Notice that the first categorizable word only indexes the possible device. The second categorizable word defines the particular device. In other words, notice the reflexivity of the membership category device process.

Conversational analysts have also followed early abstract linguists in searching for slots in conversation, independent of conversational context. For example, linguists have searched for sentence slots or segments such as nouns, and verbs. Schegloff (1967, 1968), and Sacks (1965–1968), independently and together (Schegloff and Sacks, 1973), along with Jefferson (Sacks, Schegloff and Jefferson, 1974) have been the principle investigators of conversational segments or slots. Schegloff (1968) and Sacks (1965–1968) both identified and elaborated the conversational segment or slot called paired utterances. An example of a paired utterance is the greeting. One speaker's "hi", "hello" or "howareya" summons its pair, a return greeting from the other speaker. Other paired utterances include questions—answers, conversational closings and summons—answer. In addition, these paired utterances are described as sequential, one always occurring before the other.

In order to talk of two utterances or activities as a sequenced pair, one must speak of their "conditional relevance". (Mehan and Wood, 1973, p. 127)
That means that the occurrence of the first item of the pair, a question for example, makes the expectation of the second, an answer.

Schegloff (1968) has further studied the paired utterance, greetings specifically found in telephone conversations. He found that the greeting may be accompanied by a self-identification which is composed of (1) a frame and (2) an identification term. Illustration 2 and 3 demonstrates this organizational feature.

Greeting + Self-identification
frame + identification terms
(Hi, Hello, + (this is) + (first name, etc.)
etc.)

Answerer's Greeting Slot
Illustration 2

Greeting + Self-identification + Request for identification
frame + self-identification + frame + other identification
(Hi, Hello, + (this is) + (may I ask) +
etc.) (first name, etc.) (who is this)

Caller's Greeting Slot
Illustration 3
Schegloff further states that, for the answerer's slot:

1. greeting can stand alone.
2. self-identification can stand alone.
3. the order of the greeting and the self-identification is not obligatory.
4. if the frame occurs, the identification term is obliged.

for the caller's greeting slot:

1. greeting can stand alone.
2. self-identification can stand alone.
3. request for other identification can stand alone.
4. the order of greeting slot is not obliged.
5. if the frame occurs, the identification is obliged.

Turn-taking and the distribution rule, the third organizational features to be discussed, are closely related. These features have been of interest to researchers such as Schegloff and Sacks (1973) along with Jefferson (Sacks, Schegloff and Jefferson, 1974). These investigators observed conversational regularity in that speakers talk one at a time, taking turns with few gaps or overlaps. This suggests a formal turn-taking system. One aspect of this system is the distribution rule for first utterances in a conversation. Simply stated, when a conversation begins, one individual speaks first then the other person speaks such as in a greeting. A related organizational feature
is the sequencing rule which states that speakers organize talk by alternating their speaking which can be illustrated AB, AB (where A represents the utterances of one speaker and B represents the utterances of the other speaker).

Another feature of the turn-taking system has been called the speaker selection rule. This rule suggests that there are transition points in a conversation where the current speaker can exit and a new speaker can enter. At these transition points the current speaker, as well as another speaker, has the option to select the next speaker. This turn-taking system operates in paired utterances discussed previously.

Ziferstein (1972) studied a different feature of conversation, conversational disruptions focusing on "almost-verbalized errors" and overlapped tag-positioned address terms. (The overlapped tag-position address term occurs, for instance, when one speaker says "bye bye" between the words "okay dear" of the other speaker.) These features might be called accidents or mistakes in conversation. This study concluded that:

1. these disruptive events are systematically derived.
2. the participants orient to the systematic aspects of the events.
3. disruption events can pose conversational problems.
4. the participants use systematic solutions for the problems.
5. the solutions depend upon shared knowledge of the participants.

Schegloff (1977) further developed the concept of error-correction (almost verbalized error is one type of an error-correction) but preferred to use the term "repair." Schegloff based this work on that of Bolinger (1965), a linguist. Bolinger identified two types of repairs, (1) self-correction, and (2) other correction. In self-correction, the maker of the error corrects it. In other correction, one, other than the error maker, corrects the error. Schegloff states that:

1. a repair may be found when no hearable error is made.
2. an error may be made but not repaired.
3. an error replacement is not always involved (such as in a search for a word).

According to Schegloff, the repair feature is composed of (1) initiation of repair, and (2) outcome of repair, which can be made by the same individual or different individuals. This investigation indicated that there are substantive differences between self repairs and other repairs related to (1) the placement of the repair outcome and (2) the number of utterance turns from initiation to completion. Schegloff concluded that, in adult conversation, there is preferential
use for self repairs as opposed to other repairs. In fact, only repair initiation is normally done by the non-erring individual. Normally the repair outcome is accomplished by the individual making the error.

The last study of this general type is that of Litton-Hawes (1976). This study, unlike the others, focused on a particular type of talk in a particular context—medical interviews. The question central to this study was, how does a patient and a physician co-select the topic of the talk. The data for this study consisted of 16 videotapes of initial doctor-patient interviews which were transcribed. This study identified eight rules for topic co-selection:

1. Doctor Question Rule: When a doctor asks a question about topic X, the patient, in their response, is obliged to imply topic X.

2. Patient Clarification Rule: If a doctor asks a question about topic X, the patient may ask a question about topic X before answering the question.

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

4. Patient Ellipsis Rule: (An elliptical response is an utterance which omits a word or words necessary for the complete syntactical construction for understanding.) If a patient answers a doctor's question with an ellipsis, the patient is heard as implying the same topic as the doctor.

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

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

7. Patient New Topic Rule: Patients may imply missed topics only after commenting on the topic implied in the doctor's previous turn.

8. Doctor Topic Defer Rule: If a patient implies a new topic, a doctor is not obligated to comment on the topic.

Litton-Hawes notes that these rules have three major implications. First, certain rules take precedence over other rules. For example, Rule 1 takes precedence over all other rules. Furthermore, Litton-Hawes believes that topic construction is actually related to a higher function, problem formulation.

The interview is, in essence a negotiation of words (e.g., topic) so that the doctor can take the patient's problem and turn it into something he/she can deal with successfully. (p. 93)

Second, the rule set and question structure suggest a way to study the concepts of status and power. The rule set, itself, suggests a conversational asymmetry between the doctor and patient with the doctor having more power and status. Third, the rule set implies the importance of the double interact. It takes three consecutive conversational turns or the double interact before the speakers can determine how topics are structured.

The studies presented this far take a microscopic look at conversation. The studies presented in the next section take a very different approach.
Unlike the studies described earlier, not all the research included in this Chapter utilizes conversational analysis techniques. Most of these studies use a combination of analytical techniques to investigate the phenomenon of reality. Another difference, between this research and that discussed earlier, is that the context in which the interaction takes place is of crucially important. In the studies described earlier, the rules or features of the conversational reality did not depend on or were not associated with a particular context. This point will become more apparent as the discussion continues.

Garfinkel (1967a, 1967b) has proposed that ethnomethodology study what he calls "scenic practices" or "glossing practices". He is actually suggesting the study of interactional work which includes language and other behaviors that accomplish reflexivity. Mehan (1974) defines scenic practices as descriptions of phenomena that language as well as symbolic behaviors combine to display. According to Garfinkel and Sacks (1970) scenic practices are scene specific and,

Their multitude is indicated in the endless ways that persons speak. Some indication of their character and their difference occurs in the socially available glosses (scenic practices) of a multitude of sign functions as when we take note of marking, labeling, symbolizing, emblemizing, cryptograms,
analogies, anagrams, indicating, miniaturizing, imitating, mocking up, simulating (Garfinkel, 1967a, p. 31).

Garfinkel (1967a) uses his study of Agnes to suggest the possibility of scenic practices. Agnes was a 19-year-old whose body measurements were 38-25-38. By all outward appearance, she was a woman. However, until Agnes was 16, she had been a boy. Her family treated her as a male and her birth certificate listed her as a male. In Garfinkel's study of Agnes, he found that "being" female meant more than just looking female. It meant that in specific scenes, Agnes's language and behavior (sexual scenic practices) must be within the normal possibilities of "being" female. She had to learn to be a female.

Another study conducted by Garfinkel (1967a) involves the scenic practice of documenting. In this study subjects were asked to construct yes-no questions to important personal problems. The subjects, through a microphone, asked a counselor (falsely represented) these questions. The counselor, located in another room, had a prearranged random list of yes-no answers. The comments of the subjects between questions, which could not be heard by counselors, were tape recorded. Garfinkel summarized the documenting practices he found:

1. Subjects heard the yes-no answers as answers to their questions.
2. When subjects could not immediately understand an answer, they searched for understanding.

3. Subjects changed their understanding as they went alone so that the understanding were compatible with the answers.

4. Subjects were willing to change their interpretation of their own question in order to hear the answer an answer to their question.

5. No answer was so inappropriate or so contradictory that subjects could not see its reasoned intent.

6. Subjects assumed a body of social knowledge in common with the counselor. The subject invoked whatever was necessary at any moment to document the counselor as a motivated person of good character.

Notice that the sexual and documenting scenic practices illustrate and constitute reflexivity. Garfinkel's goal has not been to enumerate all scenic practices, but to use scenic practices as a device by which the phenomenon of reflexivity can be examined.

In 1967 Sudnow, a student of Garfinkel, extensively studied two hospitals. One hospital was private and was located in a suburban area. The other hospital was a public hospital in the inner city. The focus of this study was dying, but from a unique perspective.

Rather than entering the hospital to investigate "death" and "dying" as I conceived them, I sought to develop "definitions" of such phenomena based on actions involved in their recognition, treatment and consequences. "Death" and "dying" are, from this perspective, the set of practices enforced when staff employ those terms in the course of their work day on the hospital ward....This emphasis on events as constituted by socially organized actions or procedures is specifically designed to delineate
the culture components of the phenomena in question (Sudnow, 1967, p. 8).

A complete description of all Sudnow's work will not be attempted, however, a selected sample of his findings are relevant to this study.

Sudnow found that "dying" became an important, noticeable process insofar as it serves as a way for patients and others to orient to the future, to prepare for death and to organize activities on the expectability of death. For example, associated with the process of dying are some temporal dimensions such as a person's age. In the case of a young person in the process of dying, the most noticeable feature of interaction between hospital personnel and the young dying patient is the careful avoidance of long-term future reference. In the case of an elderly patient with a terminal disease, there was no attempt by hospital personnel to avoid references to the future.

In addition, Sudnow (1974) proposes the notion of social death as opposed to physical death. Social death can be defined as the point at which socially relevant attributes of the patient begin to cease conditions for treatment. He is socially regarded as already dead. For example, autopsy preparations are made, organ donations are anticipated, family visits discontinue and last rites are often given before physiological death has occurred.
Sudnow also studied medical decisions occurring in emergency rooms (ER). For example, a young child was brought to the ER with no registering heartbeat, respirations or pulse. The ER team quickly went into action and revived the child (for eleven hours). Later that same evening an elderly person was brought to the ER and presented with the same physical signs. The medical staff made no attempt to revive the elderly person and he was declared dead on arrival. Medically, both the child and the elderly person required the same treatment, but medical decisions are made on the basis of more than physiological symptoms alone.

Sudnow's research illustrates that even clear, objective, biologically measurable facts such as death are embedded in a social context. This social context includes such factors as age, social status, "desireability" of the patient, the number of other patients in need of help at the moment, the number of staff on hand and their training, which all combine to formulate a constantly changing social definition of death.

The last research to be discussed is that of Cicourel, et al. (1974) which was conducted in two school districts in southern California. This research focused on (1) the teaching-learning process in the classroom, (2) the acquisition and use of language, and (3) the everyday school decisions made by school personnel. Data was collected via audio or
videotapes recorded in classrooms, homes and meetings. The T.V. camera was erected in full view of the participants so its presence could be routinized as part of the regular, daily activities. Although the use of video equipment did not eliminate the usual problems of field research (such as the selective attention of the researcher's observation), it did permit inclusion of many details of interaction normally missed in participant observation studies. The audio portion of the videotapes was transferred to audiotapes and then transcribed.

The strategy these researchers used has been called "indefinite triangulation". This strategy consists of comparing various interpretations of what happened from different physical, temporal and biographical perspectives (teacher's perspective, student's perspective and T.V. camera's perspective).

As with the last study discussed, only the primary results of this study will be presented. In this study, Leiter (1974) described how screening practices rely on (1) testing procedures and (2) decisions which are situationally organized. However, teachers discuss and report these decisions as though they are context free. For example, in promoting kindergarten students, teachers used social types as interpretive schemes for articulating the student as being at one level or another. In fact, in one school the practical demands of the social situation dictated that
there be a match between student social types and teacher social type.

Embedded within the use of social types and their definitions (drawn from their situated usage) were a set of practical circumstances connected with teaching kindergarten. This feature of social types and their use suggests that the social types used by the teachers were "invented" by them to recognize features of the students' behavior which if not recognized would result in the disintegration of the classroom situation. (Cicourel, et al., 1974, p. 72)

Classroom lessons were also studied and revealed that negotiated performance assessment occurs. Normative social theory states that there exists rules or requirements. In this case, the teacher has a list of rules or requirements for judging a student's response. The teacher requests a response from a student and then matches the response with the rule or requirements. The rule match determines the response correctness or incorrectness. The normative social theory, however, does not account for the findings of this study. For example, both before and after the lesson, the teacher was able to describe the correctness rule and thought that during the lesson the correctness rule was uniformly applied. Analysis of the lesson, however, indicated that the teacher accepted answers as correct that according to the rule were incorrect. Garfinkel suggests that this contradiction indicates that, the rule use in a social situation is an interpretive process involving constantly changing background features of the setting. These
background features include the child's behavior, teacher's expectation, and the question structure. Since rules cannot take all setting features into account, rules are always incomplete. The teacher's judging rules, therefore, are said to be indexical. In other words, the teacher goes beyond the rules to interpret students' responses.

If the rules are constantly being defined and refined for the teacher, the same is also true for the student who is often not told the rule in the first place. Even if the teacher gives an instruction or the rule to the students, it is necessarily incomplete, because the rule, as she knows it, is incomplete. Therefore, all the student needs to know to follow the teacher's instruction, if given, is not found in the instruction itself. As a result, the indefinite triangulation strategy indicated that the teacher's conception and the student's perception of the lesson and its purpose were very different.

Part of this study focused on the use of educational tests and test results which are used to make judgments about students and decisions about their future. After tests were conducted to assess the students' development and language use, MacKay (1974), Mehan (1974), and Roth (1974) examined the students perceptions and understandings of the testing materials.

An example of the tests and the student's perception of the test will illustrate how such tests distort a child's
reality by assuming the child has an adult reality. This, thereby, obscures the child's competence—the very phenomenon the test is supposed to measure. In a test, a child is asked to mark the picture (one out of three pictures) that goes best with the word preceding the picture (word—picture, picture, picture). In one item, the word "fly" preceded a picture of an elephant, a bird, and a dog. The "correct" answer was, of course, the bird; but many children marked elephant and bird or just elephant. When asked the reason for their choice of elephant, the children replied that the elephant was Dumbo, Walt Disney's flying elephant. Thus, the student's competence is based on the child knowing what the test constructor had in mind, not the student's intellectual development or language skills.

These tests measure only adult competence, the reality in which the world of play, fantasy, television, and work are rigorously separated. The tests do not capture the intricate and subtle ways children use language or concepts within their own realities. (Mehan and Wood, 1975, pp. 39-40)

Once the test results are tabulated and compiled, they are often used to make educational decisions concerning the future of the child. The test results, accurate or not, are used as absolute measures of a child's competence without recognizing the complexity of the interactional setting which produced those results.
Summary

The studies presented in Chapter II appear to be quite different. One group uses conversational analysis to focus microscopically on utterances which have been taken out of social context. The other group of studies takes a Gestalt approach to social reality using conversational analysis along with other techniques. The similarity, however, is that both types of studies investigate reflexivity.
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CHAPTER III

METHODS FOR THE STUDY

Introduction

The dual purpose of this study is (1) to explain and understand clinical instruction by identifying the conversational structural characteristics of clinical instruction, and generating hypotheses concerning clinical instruction, and (2) to determine the appropriateness of applying conversational analysis to investigate substantive issues in disciplines such as medical dietetics. In complying with the second goal, Chapter III provides a retrospective account of the methods and procedures found to be fruitful. This Chapter details (1) preliminary procedures, (2) data gathering procedures, (3) transcription procedures, and (4) analysis procedures.

Procedures

In addition to a retrospective account of procedures, the problems encountered at each stage will also be discussed. Hopefully, this will provide guidance for students
of conversational analysis and for those investigating phenomena like clinical instruction.

**Preliminary Procedures**

This study was conducted at Ohio State University Hospital and was reviewed by the Research Committee and the Executive Committee of the College of Medicine of the Ohio State University. The review insured that the study complies with current policy regarding clinical investigations. A copy of the application detailing this study may be found in Appendix A. A copy of the Research Committee's and Executive Committee's formal approval may be found in Appendix B.

The current policy of the Research Committee and the Executive Committee states that:

1. participants in this study must be aware of the audio taping of talk.
2. participants in this study must give informed consent in order to participate.
3. participant's identity must be kept confidential.

With respect to policy #1, all participants were made aware of audio taping by the obtrusive presence of the portable audio tape recorder. Also, a verbal request to tape conversations was made prior to starting the recorder. Recording of the conversations actually began after the request was made and these interactions were not available for analysis.
Policy #2 required that participants be informed of the purpose of the study and their formal consent be obtained. Appendix C illustrates the consent form required by the Research Committee and the Executive Committee. This form was completed by (1) students, (2) instructors, and (3) preceptors, at least days before the first taping in order to help negate any affect signing such a document might have on the conversations recorded.

It was anticipated that having the patient sign a consent form just prior to recording the conversation would affect the conversation in some way. The Research Committee and Executive Committee, therefore, permitted the following adaptation of the consent procedure:

1. The individual (usually the student) conversing with the patient verbally requests permission to record the conversation. The tape recorder is in full view during the recording.

2. After the conversation is completed and the student has left the patient's room, the investigator enters the room and explains the purpose of the study and requests formal consent from the patient to transcribe and analyze the recorded conversations. If the patient refuses to give formal consent to participate in this study, the tape recorded conversation is destroyed.
Though patients signed the consent form after taping, the presence of a taped recorder may have affected the conversation in some way.

As part of policy #2, it was also necessary to gain formal permission from physicians responsible for the participating patients. Appendix D illustrates the cover letter and permission form sent to the physicians responsible for the care of the patient participants prior to the student-patient conversations.

Policy #3 requires that the participant's identity be kept confidential. To comply with this policy, all participants were identified by a code known only to the investigator. Therefore, it is impossible to identify the particular participant from the transcripts. The tapes will be destroyed by June 1, 1977.

Target Population

The target population of this study are those individuals involved in clinical instruction. This population includes numerous service professions as identified in Chapter I. The particular service profession selected for this study was medical dietetics because:

1. the participants of clinical instruction were accessible to the investigator.
2. the environmental parameters made data collection feasible.
Sample

The following discusses the criteria used to identify the subject population and the technique used to sample from that population. The professional education of medical dietitians is two years in length. The educational stage selected for study was the mid point of the two years. This stage was selected because:

1. the concentration of clinical instruction was suited to the length of this study. (The student subject population was engaged in clinical instruction each week.)

2. the student subject population were accustom to cassette tape recording verbal interaction.

3. the student subject population were accustom to the physical environment of clinical instruction.

4. the preceptor subject population were actively and routinely involved in clinical instruction.

The subject selection technique in ethnomethodological studies is based on the same assumptions as the selection technique in anthropological studies. Since the anthropologist is interested in the shared social aspects of a foreign culture, the assumption is made that what is of interest is held or shared by each and every participant of that culture. Otherwise, an individual would not be of that culture. Therefore, random selection of study participants is meaningless. Likewise, conversational structures of
interest to ethnomethodological investigators are not idiosyncratic to any one individual, but are shared by all participants. Thus, random selection of study subjects is unnecessary. Therefore, it is an appropriate ethnomethodological sampling technique to select, as subjects, those students of clinical instruction who volunteered. It is also appropriate to study those other clinical instruction subjects (instructors, preceptors, and patients) who are associated with the volunteer student subjects by the organizational mechanism of clinical instruction.

In summary, of the 24 medical dietetic students at the mid stage of their professional education, 14 were engaged in clinical instruction activities as defined by this study. Of that number, six students volunteered to participate. The sampling technique used to determine instructor, preceptor, and patient subjects involved two steps:

1. identification of instructors, preceptors and patients associated with the student volunteers through the natural course of clinical instruction.

2. selection of those identified instructors, preceptors and patients who volunteer to participate in this study.

This sampling procedure identified two clinical instructors, five preceptors, and 47 patients.
Data Gathering Procedures

The participants in this study included (1) six Medical Dietetic student volunteers (junior year in college), (2) five preceptors, (3) two clinical instructors and (4) 47 hospitalized patients. All students, preceptors and instructors were female. This is not unusual since medical dietetics is a profession which attracts females. Of the patients participating, 21 were male and 26 were female. Of the six Medical Dietetic student volunteers, five students' conversations were included in this study. The recorded conversations of one student, which was on cassette, was lost. Of the five preceptors, the conversations of only three were recorded and included in this study. Two of the preceptors did not participate in clinical instruction during the period of this study. The conversations of the two clinical instructors were recorded and are included in this study. As a result of the lost cassette tape, the conversations of 33 hospitalized patients were included in this study. The period of this study was from June 21, 1976 to July 23, 1976 and from September 21, 1976 to December 10, 1976.

It was anticipated that some patient demographic and medical information may be of interest during the data analysis stage. Therefore, the following data was collected on each patient: (1) sex, (2) race, (3) age, (4) marital status, and (5) diagnosis. Also, the patient's hospital
number was recorded so that additional information would be available if needed.

The data for this study was gathered in three locations: (1) instructors' offices (in a University classroom building a short distance from the Hospital), (2) patient's hospital room and (3) the dietary offices of the Hospital (a non-patient area of the hospital). The equipment used in this study consisted of Memorex MRX₂ oxide cassette tapes, ninety minutes in length, two cassette recorders owned by the investigator and four recorders owned by the student volunteers. The student volunteers carried the portable, battery operated cassette recorders with them whenever they were engaged in clinical instruction activities. The students were instructed to record all conversations with patients, instructors or preceptors while participating in clinical instruction.

The curriculum structure of the Medical Dietetic Program dictates that students be involved in clinical instruction activities on certain days for a set number of hours. However, the days and hours of clinical instruction can be adapted to the particular student's needs or the particular clinical or patient situation.

During the study period from June 21, to July 23, a change in the Medical Dietetic curriculum was made which had some affect on the data collected. During this period, the students were asked to devise small research studies based
on a given number of dietetic problems. These studies usually involved patient interviews (using an interview schedule) during clinical instruction for the purpose of gathering data for their study. In comparison, the typical student clinical instruction activities involved interviewing patients (not using an interview schedule) focusing on the patient's particular dietary problem. The purpose of the typical interview was to gather patient information so that the patient's dietary problems could be resolved.

Since the period from June to July was not entirely typical of all clinical instruction activities, data was also gathered during the period from September to December. During this second period, the more typical student clinical instruction activities described above were conducted.

A brief account of the recording procedure may help those conducting similar studies. In the case of the student conversing with either the instructor or the preceptor, they simply initiated recording at the start of the conversation since all parties were aware of the study and had given prior consent. It is likely, however, that some utterances, greetings for example, occurred prior to starting the recorder.

In the case of the student conversing with the patient, the student selected the patient based solely on the student's clinical instruction activities. The student, upon entering the patient's hospital room, asked permission from
the patient to record the ensuing conversation. All pa­tients agreed. The student started the recorder and began the conversation. When the student finished, she stopped the recorder and left the room. The student notified the investigator of the patients who were interviewed. The in­vestigator collected the demographic data listed previously and went to the patient to explain the study and gain formal consent. In only one case did the student talk to the same patient more than once. One student conversed with the same patient twice.

During both study periods, all conversations which were recorded would have taken place whether or not they had been recorded.

**Transcription Procedures**

The transcription process followed three steps in an attempt to assure that the transcriptions were accurate reproductions of the cassette tapes. The equipment used for this purpose was a Teac A-350 stereo cassette deck, Pioneer SE-50 stereo headphones, and Heur stopwatch.

The transcription symbols used in this study conform to the conventions of Sacks, Schegloff and Jefferson (1974). Since understanding the transcript symbols are vital to understanding the data discussed in Chapter IV, the symbols have been elaborated here.
### I. Sequencing

<table>
<thead>
<tr>
<th></th>
<th>V:</th>
<th>M:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Th'guy says tuh me- hh my son // didid.</td>
<td>Wuhjeh do:.</td>
</tr>
<tr>
<td>V:</td>
<td>I // left my garbage pail in iz // hallway.</td>
<td>A multiple-overlapped utterance is followed, in serial order, by the talk which overlaps it. Thus, C's &quot;Vi:c,&quot; occurs simultaneously with V's &quot;left,&quot; and her &quot;Victuh&quot; occurs simultaneously with &quot;hallway.&quot;</td>
</tr>
<tr>
<td>C:</td>
<td>Vi:c,</td>
<td></td>
</tr>
<tr>
<td>C:</td>
<td>Victuh,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ]</td>
<td>V:</td>
<td>M:</td>
</tr>
<tr>
<td></td>
<td>Th'guy says tuh me- h my son didid.</td>
<td>Wuhjeh do:.</td>
</tr>
<tr>
<td>[ ]</td>
<td>M:</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>&quot;I mean no no n'no.</td>
<td></td>
</tr>
<tr>
<td>M:</td>
<td>[[P't it back up,</td>
<td>Double brackets placed in front of two serially transcribed utterances indicate that they start simultaneously.</td>
</tr>
<tr>
<td>V:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ [ ]</td>
<td>M:</td>
<td>V:</td>
</tr>
<tr>
<td></td>
<td>&quot;I mean no no n'no</td>
<td>[[P't it back up,</td>
</tr>
<tr>
<td>V:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V:</td>
<td>Y'know?</td>
<td></td>
</tr>
</tbody>
</table>

The double obliques indicate the point at which a current speaker's talk is overlapped by the talk of another.

An alternate system is to place a single bracket at the point of overlap, and place the overlapping talk directly beneath the talk it overlaps.

A single right-hand bracket indicates the point at which two overlapping or simultaneously started utterances end, if they end simultaneously, or the point at which one of them ends in the course of another, or the point at which one utterance-component ends vis-a-vis another.
In general, the equal signs indicate 'latching'; i.e., no interval between the end of a prior and start of a next piece of talk. It is used for the relationship of a next speaker's talk to a prior speaker's; for the relationship of two parts of a same speaker's talk, and as a transcript convenience for managing long utterances which are overlapped at various points, in which case a through-produced utterance may be more of less arbitrarily broken up.

An equal sign at the end of one speaker's utterance, followed by the combined equal sign and double brackets indicates that the bracketed speakers have started simultaneously, and with no interval between that talk and the preceding talk. This may occur for a speaker following by two others, or for one 'continuing' speaker and one other.

An alternate system, which is used in this transcript, is to place double obliques in the course of what is treated as a single ongoing utterance by a first speaker.
V: Ya:h, Well I woulda picked it up.
M: [I mean no no n'no.]=
V: [P't it back up, =]
M: Ih doesn' make any-
V: It doesn' mattuh.]=
M: If it breaks]
V: So dih gu:y]says 'hh

(0.0) V: ...dih soopuh ul
   clean it up.
   (0.3)
(): hhehh
V: No kidding.
M: Yeh there's nothin
   the:re?
   (0.5)
M: Quit hassling.
V: She's with somebody
   y'know hh ennuh,
   (0.7) she says Wo:w...
-- V: I'm intuh my thing,
   intuh my: -- atti-
   tude against othuh
   pih- 'hh

II. Sound Production

? ? ! V: Becuss the soopuh
dint pudda bu:lb on
dih sekking flaw en
its burnt ou:t?
V: A do:q? enna cat is
diffrent.
R: Wuhjeh do:.

A right-hand bracket plus equal sign indicates that two utterances have ended simultaneously and will be 'latched' onto by a next. In this case, the two prior are latched onto by two simultaneously-starting nexts.

Numbers in parentheses indicate elapsed time in tenths of seconds. The device is used between utterances of adjacent speakers, between two separable parts of a single speaker's talk, and between parts of a single speaker's internally organized utterance.

The double dashes, rarely used in this transcript, indicate an untimed pause, e.g., a 'beat'.

Punctuation markers are not used as grammatical symbols, but for intonation. Thus, a Question may be constructed with 'comma' or 'period' intonation, and 'question-intonation' may occur in association with objects which are not questions.
So dih gu:y sez 'hh

Yeh it's all in the chair all th/at junk is in the chair.]=

Wo::::::w]=

=I didn't know that?

I sez y'know why, becawss look.

'M not saying he works ha:rd.

I don' work ha:rd.

Does he work ha:rd?

He said- yihknow, I get- I get sick behind it.

I'd a' cracked up 'f duh friggin (gla-i(h)f y'knno(h)w it) sm(h)a(h) heh heh.

So I sez, 'hh wa:l whuddiyou goin do
M: Jim wasn't home, //⁰
(when y'wen over
there)

V: En it dint fall OUT!

* V: BU(h)D I'M NO(h)T
I(h)NTUH
THA(h)*T!**

The degree sign indicates that the talk it precedes is low in volume.

Upper case indicates increased volume.

Asterisks indicate non-speech sounds, e.g., thumping fist on table.
They may be produced by speaker or another.

M: I'd a' cracked up 'if
duh friggin (glä-i(h)f
y'kno(h)w it)
sm(h)a(h) heh heh

M: Jim wasn't home,
//⁰(when y'wen over
there)

V: I'll be
(right witchu.)
(back inna minnit,)

Single parentheses indicate transcribers are not sure about the words contained therein. Pairs of parentheses, as in the third instance, offer not merely two possible hearings, but address the equivocality of each.

Empty parentheses indicate that no 'hearing' was achieved. On occasion, nonsense syllables are provided, in an attempt to capture something of the produced sounds.

The speaker designation column is treated similarly; single parentheses indicating doubt about speaker, pairs indicating equivocal possibilities, and empty parentheses indicating no achieved identification of speaker.
Materials in double parentheses or double brackets indicate features of the audio materials other than actual verbalization, or verbalizations which are not transcribed. Occasionally an attempt is made to transcribe a cough (which might appear as "eh-khookh!") or a razzberry (which might appear as "pthrrrp!").

A number of additional symbols, not found in the symbol conventions above, have been used in this study. The additional symbols are:

IV. Syllable or Letters Not Pronounced

( ) A: Are ya goin(g)?
B: Pro(ba)bly.

The use of parentheses within a word and containing alphabetical letters indicates a syllable of the word which was not pronounced.

V. Sound Production

+ A: °OK.:.:.: do you know what ta do?

The small cross sign indicates that the talk it precedes is a return-to-normal volume. The cross sign usually follows the degree sign which indicates that the talk it precedes is low in volume.

VI. Reader's Guide

A: ( 2.5 )
I just wanted ta know ( 2.0 )
(I really do)

When utterances are not clearly audible, an attempt was made to estimate what was said. The
parentheses indicates the less-than-clear utterances. When the parentheses stand alone, the utterance was not audible and no attempt was even possible.

The first step of the transcription process involved transcribing all cassette tapes by hand and inserting transcription symbols. This step required ten to twenty hours per 45 minute tape. The second step of the process was to type the hand written transcriptions. The third step had a dual purpose. The cassette was replayed so that (1) time lapses could be inserted, and (2) the accuracy of the transcriptions could be carefully checked. This part of the process required five to ten hours per 45 minute tape.

There are a total of 56 conversations recorded of which 40 were transcribed. One cassette was lost containing 14 conversations and two conversations were so inaudible that transcribing was not possible. Two conversations were inaudible because of a loud, constant background noise while the recording was made. Table 1 depicts the number of conversations recorded and the participants of those conversations.

Analysis Procedures

This portion of Chapter III is antedotal in nature in that it will attempt to, (1) explain retrospectively the intuitive analysis approach which is characteristic of
Table 1
Participants of Conversations Recorded

<table>
<thead>
<tr>
<th></th>
<th>Students</th>
<th>Patients</th>
<th>Preceptors</th>
<th>Instructors</th>
<th>Preceptors and Instructors</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>14\textsuperscript{a}</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>#2</td>
<td>15\textsuperscript{b}</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>#3</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>#4</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>#5</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>#6</td>
<td>13\textsuperscript{b}</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>47</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Cassette was lost so recorded conversations were not transcribed.

\textsuperscript{b}One conversation of Student #2 and one conversation of Student #6 were inaudible and were not transcribed.

ethnomethodology, and (2) provide guidance for those embarking on similar studies. Initially, the transcripts were classified by participants engaged in the conversation in the following manner:

1. Student and instructor
2. Student and preceptor
3. Student and patient
4. Student, preceptor and patient

5. Student, preceptor and instructor

During repeated readings of the transcripts, notes were made in the margin to identify topic openings and closings, question-answer slots and subject content. After many readings, procedural steps which seemed appropriate were outlined. These steps are listed below:

1. Make initial search for topic openings-closings, and question-answer sequences for one transcript in each classification.

2. Identify conversational participants who initiated openings-closings, and question-answer sequences for one transcript in each classification.

3. Identify conversational participants who possess subject matter knowledge.

4. Formulate preliminary conversational structures for each transcript classification.

5. Identify structures in a second set of transcripts, one transcript from each classification (if more than one transcript exists in that classification).

6. Compare the structures identified in step #4 and step #5.

7. Reformulate and refine structures identified in step #6.

8. Identify structures found in all remaining transcripts in each classification.

9. In each classification compare structures identified in step #3 and step #4.

10. Compare the structures identified across the four classifications of transcripts.
11. Refine conversational structures for each class of transcriptions and select examples from transcriptions for illustrating structures.

Step #1 was lengthy but relatively simple, technically. However, this step did not immediately identify clinical instruction structures. It seemed, rather, to identify general conversational format. During this period, additional notes were made in the margins in an attempt to provide direction for further analysis.

The process in steps #2 and #3 began to identify the differences between the classifications of transcripts. In other words, the participant in one class of transcripts may initiate topics for conversation and the same participant in another class of transcripts may not. The process in step #1 was continued by each utterance as a topic opening, closing or question-answer slot. This process seemed to provide little additional information and therefore was continued for only selective utterances.

The initial information, which surfaced from steps #1 through #3, were assembled into preliminary conversational structures. These structures were then used to attempt to predict the conversations initially analyzed to see if they remained faithful to the data upon which they were based. Some minor refinements of the structures were then made.

In step #5 a second set of transcriptions (one conversation transcription from each classification) was studied to identify the structures of those conversations. Although
this step entailed a repeat of steps #1 through #4 for a new set of transcriptions, it took less time and was less difficult since a proposed procedure had been established in steps #1 through #4.

The procedures in steps #6 and #7 compared by class, the structures identified in each set of transcriptions. The structures, which were not found in both sets, were put aside for further consideration. During these steps, three questions arose which directed further efforts. These questions were:

1. Who controls the conversation?
2. How was conversational control accomplished?
3. How was conversational control related to subject matter knowledge?

Step #8 was similar to the procedure in step #5 using all remaining transcriptions. This step identified some of the same structures as those in steps #4 and #7 as well as a number of new ones.

In step #9, all structures were reviewed. If contradictions arose between structures or if structures were found in only one set of transcripts, more extensive review of those structures was made. If insufficient evidence was found to support the structure, the structure was eliminated.

Once all remaining structures were assembled and refined, by classification, a comparison of structures across
classifications was made.

Step #10 identified the commonalities between conversations involving different participants. More interesting, this process identified the differences between conversations involving the same participant. In other words, this process identified the structural differences and similarities between conversations involving a student and an instructor and the conversations involving a student and a preceptor.

Step #11 included a final refinement of the structures for each class of transcriptions. In addition, step #11 resulted in a review of all the transcripts to select samples which were representative of the structures. The objective of this process was to select (1) examples which clearly illustrate the structural characteristic being discussed, and (2) examples which can be examined out of context without confusion.

In addition to the described analysis procedures, many unproductive avenues were attempted at various stages. These are not included for that reason. However, this discussion does attempt to provide some suggestions for others engaged in this form of research.

Summary

This chapter briefly discusses the productive analysis procedures used in this study. A serious attempt was made
to adhere to the data-gathering and analysis criteria identified by Litton-Hawes (1976).

Chapter IV discusses the results of the analysis procedure described in this chapter. Chapter V discusses the hypotheses, concerning clinical instruction generated by this investigation and conclusions and recommendations concerning conversational analysis.

CHAPTER IV

STRUCTURES OF CLINICAL INSTRUCTION

Introduction

This Chapter presents the results of the observations of talk in clinical instruction of Medical Dietetic students. The results are grouped according to the following classification system:

1. Participants
   a. diads
      (1) student-instructor conversation
      (2) student-preceptor conversations
      (3) student-patient conversation
   b. triads
      (1) student-preceptor-patient conversations
      (2) student-preceptor-instructor conversations

2. Structure
   a. talk
   b. instruction

The term "structures" should not be equated with rules. Rather structures are the components of the conversations which appear to be significant by their frequent and
universal presence in the "doing" of clinical instruction.

As each characteristic is described, an example is presented to illustrate that characteristic. Since the context in which the conversation occurred is of importance, some brief comments concerning the context are made preceding the example.

**Turn-Taking Structure**

Utterance turns are a basic characteristic of all the classes of conversations observed during this study. For this reason, the utterance turns within a series will be discussed. The turn structure will be repeatedly referred to in the remaining discussion of this study's data.

Sacks et al. (1974) has observed that turns within a series usually exhibit a three-part structure:

1. The first or past-part addresses the relationship of the present turn to a previous turn.
2. The second part occupies the present turn.
3. The third part relates the present turn to the future or next turn.

The following example illustrates the three-part turn structure.

1: You say you like ice cream. It would also be helpful to know if you like other desserts.

The utterance part, "You say you like ice cream" refers to the previous turn and therefore is the first, or past part according to Sacks. "It would also be helpful to know..." occupies the present part of the three-part utterance turn.
The utterance part, "...if you like other desserts." is related to the next turn and therefore is the future part.

Diads

This portion of Chapter IV discusses the results of the observation of talk between (1) a student and an instructor, (2) a student and a preceptor, and (3) a student and a patient.

Student-Instructor Talk Structures: Characteristics of Talk

Student-instructor conversation took place either in the instructor's office or the dietary office (a non-patient area of the hospital). The following student-instructor talk structure characteristics will be discussed:

1. question-answer sequence
2. topic introduction and selection
3. topic closure

Question-answer Sequence:

The most obvious characteristic of this talk is the question-answer sequence. Typically, the instructor asks a question and the student answers the question. The following are two examples of this characteristic:

(1) The discussion takes place in the dietary office and involves the student's clinical assignment.

I: ah...tell me what you're working on...at this moment=
S: right now I'm just looking up values in Bowes and Church.
I: okay um...
S: writing um down=
I: oh you're not going to the computer then?
S: no I just using [this] she using the computer in there
I: okay.

(2) The discussion occurs in the instructor's office and involves the dependent and independent variables and the statistical analysis procedures of an experimental study which is to be conducted by the student.

I: why did ya give up patient working hours?
S: because id be like four variables and we couldn't handle it.
I: okay, explain to me explain to me that it'd be foure variables.
S: what from what I understood I can give you an example with like marital status=
I: okay gime that.
S: if I have like one is married//two is widowed//an I come up with a score like 1.5 there's no rationale//for the number there's nothing//they can
I: oh
This question-answer sequence is similar to the sequence Mehan (1974) found in his study of classroom teaching in primary schools. The major difference is that there is more than one student in the classroom, whereas, there is only one student involved in each conversation in this study. When the question-answer sequence is altered, the alteration involved the student asking the question. However, the instructor's answer is usually another question so that the basic sequence immediately returns. In essence, the student actually answers her own question. Example #3 illustrates this characteristic.

(3) Student and instructor are making plans to meet at a later time.
I: um::m:(0.5) so that:(0.5) you're not all that rushed but if you can have that, like by Monday an we can sit down an work it Monday you're gonna be better off:(0.5) when ya go ta write it//so Monday is class right—see me after class on Monday:(1.0)
S: ye
S: okay you don't wanta see me tomorrow?:(0.8)
I: am I suppose ta see you tomorrow?:(1.0)
S: I don't know. I guess I have a free morning tomorrow then don't I?
I: let's take a look at it. okay what's the date twenty third collect data an attend workshop that's what it says. does it say anything about me?
S: no I don't know uh huh
I: so you just, you'll be, you'll be still be collecting some data tomorrow I think or, or assume you've-got-it collected you need to put it down an in workable form.
S: ye.

Notice that the instructor turns the question ("ok you don't wanna see me tomorrow") of the student around and asks the student the same question ("am I suppose ta see you tomorrow"). The student asks another question ("I guess I have a free morning tomorrow then don't I"). Again rather than a direct answer, the instructor presents information, but also, returns the same question to the student.

Topic Introduction and Selection:

The second structural characteristic of student-instructor talk to be discussed are the ways new topics are introduced as related to the three-part turn structure. The following examples illustrate turn-taking and the way new
topics were introduced in this study.

(4) Instructor and student are discussing the information the student gathered.

S: well. I'll tell ya I didn't find magnesium levels too much for this so I have to say I didn't find it for the regular blenderized diet =

I: well ca(n), do ya-know that article I gave ya =

S: ye =

#1, p. 1

(5) Instructor asks the student the vitamin C content of a blenderized, liquid diet.

S: looks like point 0 two an then ya multiply it by 20 since I'm doing quarts.

I: okay +what's the recommended daily allowance a vitamin C?

S: forty-seven milligrams or something like that (mumbling)

#1, p. 3

The first utterance of example #4 by the student contains only two parts of the three-part structure. "Well.....I'll tell ya", is the part that relates to the past turn. The remainder of the utterance occupies the present turn part. The second utterance by the instructor in example #4 introduces a new topic. This turn connects the past to the future while omitting the present turn part. "Well ca(n)", relates
to the past turn in an abbreviated manner. "Do ya-know that article I gave ya?", is the turn part which connects to the future or next turn.

Example #5 is similar to example #4 in that the student's turn contains a two-part structure. One relating to the past ("looks like point 0 two"), and one occupying the present turn part ("an then ya multiply it by twenty since I'm doing quarts"). The instructor's turn contains "okay", which is an abbreviated reference to the previous turn, and therefore, is the past part of the utterance. This turn omits a present structure but contains a future part, "what's the, what's the recommended daily allowance a vitamin C?". The student's following utterance in example #5, exhibits only a present part utterance structure.

Example #6 also illustrates topic introduction.

(6) The discussion occurs in the instructor's office and involves the composition of tube feedings.

S: well most of the things they use are baby foods.

I: oh okay.

S: so I imagine it would be safe for them just blenderized//I mean-

I: umha

I: umha.okay.I'm a little concerned about, how you're going to write this up.

S: well, if I'm just going to do it as a comparison then I don't have ta.without any
In the first and second utterance of the student, only a present part occurs, "well most of the things they use are baby foods" and "so I imagine it would be safe for them just.....blenderized//I mean". The instructor's utterance that occurs between the two student's utterances exhibits only a past part, "oh okay". The last instructor's utterance introduces a new topic and contains a past part and a future part. The future part of the utterance introduces the new topic. "Umha.....okay" is the past part of the utterance and "I'm a little concerned about how you're going ta write this up" is the future part of the utterance. The last utterance of the student contains an abbreviated past part, "well"; and, the remainder of the utterance exhibits a present part.

These examples illustrate that neither the instructor's turns nor the student's turns contain a three-part turn structure. Instructors abbreviate or only imply the past part coupled with a future part utterance structure. The future part introduces a new topic. The student's utterances generally exhibit a past and present part or only a present part utterance structure. The student accepts the instructor's new topic introduction via the present part structure of their utterance. Thus, instructors introduce new topics without establishing a relationship with the old topic; and, the students accept whatever new topic the
instructor introduces.

A component of topic introduction is topic selection by all conversational participants. In other words, a topic may be introduced by one conversational participant but not accepted or understood by the other participant in a diad. Examples #7 and #8 demonstrate the structural characteristic of how topic selection was accomplished in student-instructor talk.

(7) Student explains the methodology she is using in her clinical assignment.

I: Now what you want to do is make up your test an run it by say three dietitians.
S: Okay=
I: Or a panel of some sort. Then you can: assume you have content validity=

(8) Instructor asks about the way the student plans to report her clinical study.

I: but what about the part that comes before that. your study your statement of the problem=
S: well I could say why I'm looking at it ah ya that would I: I don't know, +maybe I would say why I looking at those nutrient=
I: did we did we make an outline

#1, p. 7
In example #7, the first turn by the instructor introduces the topic. The second turn by the student accepts the topic. The third turn by the instructor indicates that the instructor knows her topic was accepted and understood so she is able to elaborate the topic. In example #8, the first turn by the instructor introduces the topic - the problem statement. The utterance turn of the student exhibits acceptance and elaboration of the topic. The third utterance turn by the instructor illustrates that her topic introduction in the first utterance turn was not heard by the student in the way she anticipated. Therefore, the instructor rejects the original topic and introduces a new topic.

In summary, the structural characteristics of topic selection in student-instructor talk requires three utterance turns. The instructor's first turn introduces the topic. The student's turn, the second utterance, accepts and/or elaborates the topic introduced. The instructor's next turn, the third utterance, accepts, and/or elaborates, or rejects the student's understanding of the topic.

Topic Closure:

The third structural characteristic of student-instructor talk focuses on topic closure. Examples #9 and #10 demonstrate how topic closure was accomplished.

(9) Student explains the calculations used to derive the vitamin C content of a liquid diet.
S: an this is per 100 milliliters\(^{(0.5)}\) so if I want two thousand milliliter=
I: okay=
S: multiply it by twenty\(^{(3.4)}\)
I: okay\(^{(6.0)}\) now\(^{(2.2)}\) an + where is Ensure?\(^{(1.9)}\)
// check that out something strange\(^{(0.5)}\) oh
Ensure is over here\(^{(4.0)}\) oh this thing is off
(kilter\(^{(1.9)}\) ) guess you're right\(^{(0.5)}\) damit
you're right\(^{(3.6)}\) okay\(^{(0.4)}\) now do they\(^{(4.4)}\) do
they very the amount given in-other-words do
they always give two quarts a day?\(^{(1.4)}\)

#1, p. 5

(10) Student and instructor discuss the magnesium content of foods as reported by a journal article.

S: so[so] they are concerned with it an that's good\(^{(1.3)}\) you are you sure well\(^{(0.3)}\) when
you're finished we'll know the sources of
magnesium won't we=I thought they were in the
meat\(^{(0.8)}\) the meat products=

I: meat for sure an I thought also milk\(^{(1.5)}\)
okay so now that\(t\) ya got all this data
whata ya go what does it mean ta ya?\(^{(1.5)}\)

#1, p. 2

In example #9, the instructor attempts topic closure by
"okay". The student continues the topic discussion but the instructor again brings closure with "okay". Although there was a six second pause after the second topic closure, "okay", the student does not attempt to further discuss the topic but accepts closure by the instructor. In example #10; the instructor closes the topic in the middle of the third turn by the word "okay". The instructor immediately introduces a new topic by requesting a new topic from the student in the same turn as the topic closure.

As examples #9 and #10 illustrate, topic closure in student-instructor talk is unilaterally determined by the instructor. Even when the student attempts to prevent topic closure, the instructor is not obliged to continue topic discussion and may reassert topic closure.

Student-Instructor Talk Structures: Characteristics of Instruction

The remainder of this section discusses the instructional characteristics of student-instructor conversations. Three characteristics will be presented, (1) focusing instructional attention via certain questions, (2) teaching by generalities, and (3) emphasizing process and product.

Instructional Attention:

The instructor is able to focus instructional attention by the particular questions she asks. As the previous examples demonstrate, the instructor requests information by
asking questions and the student provides information by answering questions. Through this structural characteristic, instructors are able to focus instructional attention on certain topics, details or facts and not on others. For instance, in example #5, the instructor brought attention to the recommended daily allowance (RDA) for vitamin C. In other words, the instructor focuses instructional attention and importance to certain topics, details or facts by the verbalization of a particular question. At the same time the instructor de-emphasizes a certain topic or detail by neglecting to verbalize a particular question. The instructor focuses instructional attention both by commission and omission of questions.

Generalities:

The second structural characteristic of instruction in student-instructor talk is the inductive process of teaching by generality. For the purpose of this study, a generality is defined as a principle around which the instructor assembles the details provided by the student. Example #11 illustrates this characteristic.

(11) Student shows the instructor the nutrient content of a list of foods.

I: but but but but what's gonna happen is\(0.5\) the error the probability a error\(0.6\)every time ya recopy it\(0.5\)ya can try it\(0.7\)I'd do this it likes, just like sometimes I'd
I wish I could get in the habit, if ya just do it right the first time. Your probability of error is less then recopying it ah your the time spent on it is less in the long run. If ya can get try ta get some a those working habits straightened away. ya get it?

In example #11, the instructor uses the information she requested from the student in previous turns, to support the generality that doing something correct the first time prevents error which occur as a result of recopying. Generalities assembled in the way previously described are, by their nature, transferable to other situations involving other specific details. In other words, the generality in example #11, things done correctly the first time prevents error later, is transferable to many other situations. It is noteworthy that one of the psychological basis of clinical instruction referred to in Chapter I is transference. (de Torngay, 1971).

The instructional characteristics described thus far are similar to those described by Carlos Castaneda (1968) in his ethnographic study of Yaqui knowledge. In this instructional structure, the apprentice (Castaneda) is asked by the teacher (don Juan) to describe in detail the situations experienced. Through the particular questions asked by the teacher, certain details are emphasized and others are
neglected and assumed to be unimportant. Once the apprentice has answered the questions and provided the details, the teacher assembles the details into a generality which is explained to the apprentice. Therefore the Yaqui way of knowledge, like student-instructor conversation in clinical instruction, is an inductive instructional process.

Process and Product:

A final instructional characteristic of student-instructor conversation to be discussed is the emphasis on process as well as product. Example #12 actually states this characteristic.

(12) S: I think.3 I'm not sure.5 I'll look that back up again=
I: that's the way you're suppose ta be thinking in-other-words I'm not, I don't care that ya don't know it.9
S: oh::h=
I: I mean that's.6 no consequence that ya don't know it.5 now I don't know it, I not sure I'm just saying in my mind it has ta be there=
S: it has ta be there
I: again so-then-what-ya-do is you you you think back something you learned an an you hook into it.9 aha I remember that, now that's
what learning's all about. if we can teach ya ta do that. then the details not all that important. until ya start working in the unit. such as this where you where you have ta have the detail at your finger tips. out ya will because. it'll come to you when you're using it. you're working on plants. metabolism you'd have that on the tip of your tongue wouldn't ya-

In example #12, the instructor states that it is unimportant that the student remembers the specific food sources of magnesium. Indeed, the instructor states that she doesn't know them, but that she thinks magnesium has to be present. The instructor further states that what is important is the student having a process by which to discover the specific information. In other words, knowing a specific answer is not as important to the instructor as knowing how to get the answer (the process by which one may derive the answer).

In summary, student-instructor talk structures are characterized by:

1. the instructor asking questions and the student answering questions.

2. the instructor unilaterally introduces topic via an utterance which exhibits a future or a future and past part.
3. the student accepts topics introduced by the instructor via an utterance which exhibits a present or a past and present part.

4. complete topic selection requires three utterance turns.
   a) instructor: topic is introduced.
   b) student: introduced topic is accepted, and/or elaborated.
   c) instructor: topic as understood by student is accepted, and/or elaborated, or rejected.

The student-instructor instructional structures are characterized by:

1. the instructor focuses instructional attention via (1) verbalizing certain questions or (2) not verbalizing certain questions.

2. the instructor assembles details and facts provided by the student into transferable generalities.

3. the instructor focuses instructional attention on the process as well as the product of the clinical experience.

Student-Preceptor Talk Structures: Characteristics of Talk

Three characteristics of the structures of student-preceptor talk will be discussed: (1) the question-answer sequence, (2) topic introduction and selection (3) topic closure and conversational closure.

Question-answer Sequence:

The first characteristic, the question-answer sequence, is illustrated in examples #13 and #14.
(13) Student asks the preceptor questions concerning her clinical activities.

S: do you feel you would have time ta ask patients a few questions concerning their understanding of menu terms?(1:7)

P: I think so.(1:3)

S: an would you be willing ta do this as part of a study?(2:4)

P: yes, if time permits.(1:2)

#5, p. 1

(14) Student asks how to mark the menu so to indicate that the patient is on the save slip (a calculated dietary intake).

S: what should I do with them then(/ta make sure that they're on the save slips=

P: okay

P: okay then, ah. (0.3) take three. (9.0) C°what ta. (1.5) rack) (0.3) check mark, ya-know all of these, if you want them saved you have ta put save slip=

#4, p. 6

In examples #13 and #14, the student asks questions concerning her particular clinical activities; and, the preceptor answers the questions. In only one conversation did the preceptor ask questions. In this instance, the preceptor asked only two questions at the beginning of the conversa-

tion. This is illustrated in example #15.
(15) Discussion involves the type and the number of questions the student should ask a patient.

P: how many ya wanna ask?=how many ya-wanna know.(1.0)
S: I don'(t) know [these two (1.0)]
P: those two?(1.5)
S: those two?(1.5)
P: how long(0.8) you have been on tube feeding
S: I don'(t) know just(0.7) just something general(1.3)
P: om(0.6) that's something you really wanna know(0.6) or is that something you made up because(1.3) you needed a question?(1.2)
S: well
S: (h)° it's more that(0.5)

Thus, the structure of student-preceptor talk is characterized by a question-answer sequence. Although the preceptor occasionally asks a question and the student answers, the predominant question-answer structure is the student asking the question and the preceptor answering.

Topic Introduction and Selection:

The second talk characteristic to be discussed is topic introduction and topic selection. Example #16 illustrates the way in which topics were introduced in student-preceptor conversations.
(16) Student explains to the preceptor her expected clinical activities and asks for permission to observe teaching. Student's first utterance was lengthy, so only the last part has been included in the example.

S: so we're gonna do that for a trial run next week in clinic... an:n maybe later on the week... um have you been teaching an counseling an things like that?

P: oh yes...

S: could I observe you sometime then?

P: sure I just got done with one.

In relation to the three-part turn structure described earlier, the first student utterance of example #16 exhibits a present part ("so we're gonna do that for a trial run next week in clinic... an:n maybe later on the week"). This utterance also contains a future part which introduces the new topic, teaching. The preceptor's utterance contains much abbreviated past part, "oh", and a present part, "yes". The student's second utterance introduces a new subtopic, observing the teaching, which is embedded in a future utterance part. The preceptor's last turn exhibits only a present part.

Example #17 also illustrates a topic introduction in student-preceptor conversations.

(17) Student asks preceptor about employees in the dietary office.
S: °okay+what now(0.5) I want ta get these names (0.5) Mrs. P (1.0)

P: okay she'll be here tomorrow (0.4) you've already talked with Mrs. S (0.5)

S: °okay ye (3.4)

In example #17, the student's first turn exhibits all three parts. "Okay" is an abbreviated past part. The present part of the utterance is "what now". The future part, "I want ta get these names.....Mrs. P.", introduces a new topic. The preceptor's turn also contains all three parts. The past part is; "okay"; the present part is, "she'll be here tomorrow"; and, the future part is, "you've already talked with Mrs. S.". The second turn of the student exhibits a past part and a present part.

Example #16 and #17 demonstrate that student-preceptor talk turns may contain any combination of past, present and future parts. There does not appear to be any predominant turn structure for either the student or the preceptor. Topic introduction, however, is predominantly accomplished by the student in the future part of the utterance.

Topic selection is closely associated with topic introduction. Example #18 illustrates topic introduction and selection in student-preceptor conversations.

(18) Student asks for information concerning a dietary office procedure.
This example demonstrates that three turns are required to complete topic selection. The first turn by the student introduces the topic—the employee who does the save slip procedure. The second turn, by the preceptor, accepts the topic introduces by the student. The third turn, by the student, acknowledges and accepts the preceptors' understanding of the topic and elaborates the topic. In student-preceptor talk, the preceptor always accepts and/or elaborates the topic introduced by the student.

The three turn topic selection characteristic of student-preceptor talk is the same structure found in student-instructor talk. The only exception is that, since the student introduces the topic in student-preceptor talk, she accomplishes turn 1 and 3. Whereas, in student-instructor talk, she does not introduce the topic, but only accepts it which she accomplishes in turn 2.

Topic Closure and Conversational Closure:

The third characteristic of student-preceptor talk structures is topic closure and conversational closure.
Topic closure in student-preceptor talk is not unilaterally accomplished, but is negotiated by the student and preceptor. Examples #19 and #20 demonstrate topic closure introduction and negotiation.

(19) Student and preceptor discuss two topics (1) observing counseling, and (2) student's clinical plans. Closure on both topics is negotiated.

1. S: okay we'll still be working on this too
   (0.7) do you have any questions for
   me? (0.4)
2. P: no. (0.8) not that I can think of. (0.5)
3. S: um. (0.5) do you kinda have an idea // of
   what we're doing?
4. P: ye
5. P: ah: a, one thing with the menu terms I
   find out that a lota people don't even
   know what zucchini is. (0.4)
6. S: umha. (0.4)
7. P: an [that more
   more
   basic. (1.0) ta start with=
   that's what Mrs. ___ said]
8. S: that's what Mrs. ___ said
9. P: rather than going inta a. (1.7) dishes. (0.5)
10. S: umkay. (1.4)
11. P: that's a thought too. (0.8) the best thing
    ta do is just check with me. (1.1) um in the
    morning a couple times or call or some-
    thing an(d) I'll let you I be able
In example #19, the student introduces topic closure by asking the preceptor if she has any questions. After the preceptor states that she does not have any questions (in turn 2), the student restates the original question in turn 3. Although the preceptor again states that she does not have questions, she reopens the topic of the student's clinical plans by making a suggestion. In utterance 9, the student again introduces topic closure; but, the preceptor returns to the topic of observing counseling. In turn 11, the student again introduces closure; but, the preceptor continues the topic discussion. In utterance 13, the student again introduces closure, but in this case, they both agree to close with turns 16 and 17. In this example, topic closure was also conversational closure.
Student asks the preceptor about the procedure for coding patient menus for computerization.

S: we don't have to actually, code them. (0.4)
    ourselves. (0.3)

P: no/ they go next door an: da the computer will do it an if you don't do it in red
    it will not. (1:3) because they figure that maybe the patient has put a one or a two an we
    have to do it in red. (0.4)

S: an

S: okay. (0.5) fine. (0.4)

P: okay. (1.3)

In example 20, the student introduces topic closure by the utterance, "okay..... fine". The preceptor agrees and completes closure by the utterance, "okay".

In summary, topic closure and conversational closure in student-preceptor talk is negotiated by the participants. However, topic closure is introduced by the student and closure is completed by the preceptor as the examples illustrate.

Student-preceptor Talk Structures: Characteristics of Instruction

Two instructional characteristics of student-preceptor talk will be discussed in this section, (1) the instructional purpose of the question-answer sequence, and (2) the
pragmatic nature of the preceptor's utterances.

Instructional Purpose:

As examples #13 and #14 demonstrate, the question-answer sequence is a common feature of student-preceptor talk. This feature is characterized by students asking questions and preceptors answering questions. In this class of conversations the purpose of the student's question is to gather information she needs to perform clinical activities. Students ask questions because they do not know the answers.

On the other hand, the instructional purpose of the question-answer sequence in student-instructor talk is to make details evident so the instructor can assemble a generality. In fact, the instructor usually knows the answer before she asks the student the question.

Nature of Utterances:

The second instructional characteristic of this class of talk is the pragmatic nature of the preceptors' verbal responses. This is illustrated in examples #21 and #22.

(21) Preceptor details the possible patient reactions to the student.

S: ye.(0:5)+cawes I'm a new.(0:3)I'm a new face

P: [right, it would
ta them just depend on how their feeling.(0:6)um.(1:0)
if they're de:pressed or up:set.(0:5)um.(0:6)
Mr. C., when he first came was so sick and we didn't even bother for a while and then finally he said, hay I want my menu! So now he does his own menu and he does very very well and he might, ya-know he's in there by himself most of the time and ya just tired of watching television//an if they're really not too sick the nurses come in just-is as they're needed.

S: umha
S: umha

In example #21, the preceptor provides pragmatic information to the student via a particular situation involving a particular patient.

(22) Student discusses with the preceptor possible questions which could be asked of a patient being fed a liquid diet through a naso-gastric tube.

S: ye I'll note that in the paper too...this is if they're taking it all (h)
P: if they're taking it all ye! for sure if-they say no:0 ya-know o they go and find out what kinda things they're not taking! like someone might turn up their nose at the vegetables,
ya-know they never liked vegetables when they were solid, an' the smell of um an' everything else.

S: they don't like um now=
P: they don't like um now...um, so you may find out they're not eating the vegetables, or you may find out that the fruit in mixture with the milk is souring in their stomach, or ya-know+something along those lines. ok an' give you a clue, ya-know, what's really goin(g) on an' maybe we can substitute something like if the orange juice is souring the eggnog may be a little apple juice id be better or something like that.

In this example the student proposes possible questions she could ask the patient. The preceptor responds by providing specific detailed patient reactions and specific dietary problems the student might encounter.

This instructional characteristic of student-preceptor talk entails the preceptor providing the student with practical, specific and detailed information as to how to actually do clinical activities. The examples presented also illustrate that preceptors do not gather details into generalities as instructors do in student-instructor talk.
In summary, student-preceptor talk structures are characterized by:

1. the student asks questions and the preceptor answers questions.
2. the student's and preceptor's utterances may contain any or all of the three part turn structure.
3. the student introduces the topic.
4. the selection of a topic requires three turns.
   a) student: topic is introduced.
   b) preceptor: introduced topic is accepted and/or elaborated.
   c) student: topic, as understood by preceptor, is accepted and/or elaborated.
5. the closure of the topic and conversation is negotiated by the student and preceptor. However, the student introduces topic closure and the preceptor completes topic closure.

The student-preceptor instructional structures are characterized by:

1. the student asking questions for the purpose of gathering information.
2. the preceptor responding to the student with pragmatic, detailed, specific information concerning how clinical activities are performed.

Student-Patient Talk Structures: Characteristics of Talk

Four characteristics of student-patient talk will be discussed in this section, (1) question-answer sequence, (2) topic introduction and selection, (3) topic closure, and (4) conversational closure.
Question-answer Sequence:

The first group of examples illustrate the question-answer sequence.

(23) Student asks the patient about dietary problems during pregnancy.

S: ok:ay.(0.6) did you ever experience any nausea or vomiting during pregnancy=

Pt: vomiting.(1.6)

S: how did you control it? (5.5) what did you do about it? (0.5)

Pt: °(I didn't) (1.3)

(24) Student asks about the anticipated length of hospitalization and the dietary habits of the patient.

S: do you know how long you'll be in?

Pt: about a week er so:o=

S: another week? (4.4) o: kay. (3.6) can you tell me what you eat at home?

Pt: poached egg on toast. (1.6) i: an then, (6)

half a cup a orange juice. (1.4)

#10, p. 1

(25) Student asks about get-well cards displayed in the patient's hospital room.

S: you've got a lota cards here ta read. (1.0)

Pt: oh jesus christ. (0.3) mother took home over a hundred=

S: oh you're kidding. (0.5)
These examples illustrate the question-answer sequence in student-patient conversations in which the student asks the questions and the patient answers. There were only two exceptions to this student-question and patient-answer structure. The three types of instances in which the patient asks questions and the student answers questions are:

1. when the student asks if they (the patient) have any questions.

2. a unique instance which will be subsequently discussed under ritual disruption (Example #37)

3. when there is an embedded question-answer sequence. Example #28 illustrates this structure. Briefly, an embedded question-answer sequence occurs when

   a) the first utterance asks a question.
   b) the second utterance asks a question usually to clarify the first question.
   c) the third utterance answers the question in the second utterance.
   d) the fourth utterance answers the question in the first utterance.

Topic Introduction and Selection:

The second student-patient talk characteristic to be discussed is topic introduction and selection. Topics were introduced by the student in an utterance which did not contain all three past, present, and future parts. For instance, in example #23, the student introduces the topic of nausea and vomiting in an utterance which exhibits an
abbreviated past part, "okay", and a future part, the remainder of the utterance. In the next student utterance in that same example, "how did you control it? what did you do about it?" only a future part is present. In addition, both patient turns in example #23 exhibit only a present utterance part.

In example #24, the first student utterance, which introduces a topic, contains only a future part. The second student utterance in that example exhibits a past part, "another week?, and a future part, "can you tell me what you eat at home for breakfast." The future part of that utterance introduces a new topic, breakfast. Both patient turns of example #24 contain only a present part.

In example #25, the student's first utterance contains only a future part which introduces a new topic. The second student's utterance exhibits only a past part. Both patient utterances contain only a present part.

In summary, students introduce new conversational topics employing a turn which contains a past and future or only a future part.

There are occasions, however, when a patient attempts a topic introduction as in example #26.

(26) S: okay.\( ^1\). do you know what gelled cider fruit salad is?\( ^1\).?
Pt: I have a feeling I'id had cider.\( ^0\).\( ^9\) an gello and I can't drink cider so\( ^1\).\( ^2\).
S: okay.(8).
Pt: (puts me in an uproar)(0:9)
S: so you think there would be gello an cider in it(1:0)
Pt: ye=

The student, in example #26, introduces the topic, the patient's knowledge of gelled cider fruit salad. The patient attempts to introduce a subtopic, her idiosyncratic reaction to cider. In the last student turn of example #26, the student does not acknowledge the patient's subtopic but continues the topic she introduced. The patient acknowledges (1) the student's topic and (2) the student's neglect of her subtopic by the abbreviated utterance, "ye". In summary, although the patient accepts the student's topic introduction, the student is not obligated to accept the patient's topic introduction.

As mentioned in previous segments of the Chapter, topic selection is intimately related to topic introduction. In student patient talk, two structures for topic selection were observed. Example #27 illustrates topic selection which requires two turns.

(27) S: okay(0:9) ah who prepares, all the meals?(0:5)
Pt: me(5:3)
S: were you given any nutritional information or(0:7) an-special counseling during your
In this example the student's first utterance introduces the topic. The second utterance, that of the patient, implies acceptance by answering the student's question in which the topic introduction was embedded. The student in the third turn introduces a new topic without any reference to the patient's understanding of the old topic. Hence, the topic selection takes only two turns.

Another topic selection structure of student-patient talk requires three turns. This is demonstrated in example #28.

(28) S: how many times do you eat per day?\textsuperscript{2.8}
Pt: how many times I eat then?=
S: right.\textsuperscript{2.3}
Pt: I'd say about four times.\textsuperscript{2.1}

In this example, the student introduces the topic in the first turn. In the second turn, the patient elaborates the topic. The student in the third turn accepts the patient's understanding of the topic. Hence, three turns are required to select the topic. The three turn topic selection structure was the predominant structure observed in student-patient talk.
Topic Closure:

Topic closure is the third characteristic of student-patient talk. This conversational feature was unilaterally accomplished by the student as example #24 illustrates as well as the following example.

(29) Student asks about the patient's home dietary habits and decides to help the patient select a menu for the next day.

S: um okay.(1.8) do you have a snack before you go to bed.(1.8)

Pt: well if I do, its a little bread an milk, er crackers er.(1.0) most generally I don't!(5.2) just according to how much(1.5)

S: umha.(2.0)+o:k.(3.4) might as well select a menu for tomorrow.(1.1) since you'll be back on a regular one.(1.0) would you like some orange juice or prune juice?(1.0)

#10, p. 4

The student, in example #29, unilaterally closed the topic of the patient's home dietary pattern with the utterance "umha...o:okay". The student then, immediately initiated a new topic within the same utterance turn.

Conversational Closure:

The fourth characteristic of student-patient talk which will be discussed as conversational closure or topic closure at the end of the conversation. Unlike topic closure within
the conversation, topic closure at the end of a conversation can be negotiated between the student and the patient.
Example #30 demonstrates this characteristic.

(30) Student discusses with a new young mother, her dietary habits while pregnant.

S: ya have any kin(d), any question? concerning [nutri]

Pt: ye why is why am I doing this, whay er ya doin(g) why, why does this have ta be, does this have ta be done, or why is it been doin(g) ?

34 utterance turns separate these sets of utterances

S: okay well to you have any question +other questions for me=

Pt: na::aw=

S: no? well +thank you very much=

Pt: um::ha=

S: +for +lettin(g) me talk ta you, an gettin(g) this information.

Pt: okay(1.5)

S: by-by

The first section of this example demonstrates the student's attempt to negotiate a conversational closure by asking if the patient had any questions. The patient was not prepared
for closure which was demonstrated by her question. The conversation continued for 34 more turn-takings. At that point the second section of the example occurred in which the student again attempted to negotiate closure. The negotiation was successfully completed; and, the conversation was terminated.

Although conversational closures were negotiated, closures could also be unilaterally accomplished by the student. Example #31 exhibits this closure feature.

(31) Student asks the patient about her/his understanding of a number of menu terms.

S: okay you think it's a fruit salad?!

Pt: um ha.

S: okay that's all I need to know then.

As this example illustrates the student did not permit bilateral participation by the patient in conversational closure. In summary, students may negotiate conversational closure with the patient; however, they are not obligated to do so.

Student-Patient Talk Structures: Characteristics of Instruction

Ritual:

One characteristic of instruction in student-patient talk was observed. For the purpose of this study, this feature is called the ritual student utterances which is defined as the student's conversational observance of
prescribed (by the student, herself) utterance forms. This ritual nature of student utterances has four components:

1. the topics of the conversations.
2. the order of topics introduced.
3. the format of the student's utterances.
4. the range of possible utterances allowed the patient.

This ritualistic feature becomes most apparent across student-patient conversations involving the same student. The following two examples, #32 and #33, demonstrate the four components listed above.

(32) Student is speaking with a new, young mother.

S: °all right before your pregnancy, what did you weigh?°(1.0)
Pt: one-twenty-six=
S: one-twenty-six?(1.9)°okay.(1.2)ah=have you ever had any problems your weight?(1.2) prior to pregnancy(0.5)
Pt: I usually weigh ah.(0.6)one-thirty-five.(0.7)! that's as much as I ever weighed=
S: uh.(0.6)okay.(1.5)so you, were you ever over-weight or underweight?(0.5)
Pt: no=

(33) Same student is speaking with a different, new young mother.

S: okay.(1.3)um, before your pregnancy di(d)
you-know-what you weighed? (0.5)

Pt: about a hundred and twenty=

S: hundred and twenty? (0.8) okay (0.9) + did you ever have any problems with, your weight? (1.2)

Pt: no (1.0)

S: that you can remember? (0.5)

S: no?, okay (0.5) + ever been overweight or underweight? (0.5)

Pt: overweight (0.7)

Although these conversations took place with different patients at different times, they are nearly identical with respect to:

1. the topics of conversation.
2. the order of topics introduced.
3. the format of the student's utterances.
4. the range of possible utterances allowed the patient.

It was observed that the ritual nature of student's utterances can be disrupted (1) by the student, and (2) by the patient. The student, over time, disrupts her own ritual without disrupting the conversation as a whole. The ritual components which are disrupted by the student are:

1. the order of topic introductions.
2. the format of the student's utterance.
This method of disruption is illustrated in examples #34 and #35.

(34) Student talking with a new young mother about her future plans.

S: okay.\(2.0\) how are you feeding the baby, breast or bottle?

Pt: bottle=

S: bottle?\(1.5\) kay, what, what, um reasons do you have for that decision?\(2.0\)

Pt: I I I don't have.\(0.5\) I don't believe I would wanta breast feed my baby.\(2.6\)

S: you just have no, desire?\(1.5\) okay.\(3.8\)

Pt: *huha.\(0.5\)

S: *no.\(0.6\) okay.\(3.2\) how many years of school have you completed?\(1.0\)

Pt: well, I finished past the eleventh grade.\(0.8\)

S: *okay.\(5.0\)

Pt: [ 3.8 ] =

S: you plan ta finish?\(0.6\)

Pt: umha=

S: okay.\(5.8\) are you on that WICK program?\(0.7\)

#7, p. 11

(35) Same student speaking with a different new young mother.

S: *okay, +how do you plan ta feed the baby.\(2.0\)
Pt: ( you mean. )
S: um: m, breast er bottle.
Pt: bottle
S: bottle. what are your reasons for choosing bottle over breast.
Pt: so ma breasts won't sag.
S: so they don't sag? given any nutritional information about breast feeding?
Pt: I have some over here.
S: umha=
Pt: they gamme some
S: [ right when ] ya got here =
Pt: umha.
S: how about before ya come here?
Pt: "huha.
S: all right, how many years a schooling ( have you completed )
Pt: two.
S: two years a high school=
Pt: umha, but I, I'm goin(g) ba::ck.
S: so up ta the tenth grade, you finished=
Pt: ye.
S: you're gonna ga back? I see, what, come, fall, you're gonna go back an finish=
Pt: ye.  
S: what're your plans, when you leave here with the baby?  
Pt: m:m. I, a like my mother she'll pro(ba)bly be workin(g). ya-know in the daytime an in the night, an I come. ya-know child she'll help with the baby  
S: umha. di(d) chor mom give ya any kinda information as to what you should be eating er.  
Pt: [she, you mean] after I have a baby=  
S: no whi while you were pregnant. di(d) she give ya any advice  
Pt: [she told me] ta, eat alota vegetables. don't eat too much sweets an candy.  
S: umha.  
Pt: an watch ma diet.  
S: did ya watch it pretty good? how much weight did ya gain, during your pregnancy?  

In comparing ritualistic example #33 and the less ritualistic example #34, the following observations can be made:
1. In example #34, the student's utterance is often not related to the patient's previous turn. In example #35, the student's utterance is based on or related to the patient's previous turn.

2. The format of the student's utterances in example #35 are less formal than the student's utterances in example #34.

3. The introduction of new topics in example #35 is based on the patient's previous turn. New topics introduced in example #34 are not based on the conversational flow of the patient.

The second way, in which the ritual nature of student-patient conversations can be disrupted, is accomplished by the patient. Example #36 illustrates this type of ritual disruption.

(36) Student asks the patient whether a menu item was what she expected it to be.

1. S: was this exactly what you expected, almost what you expected, or completely different from what you expected.(O.4)

2. Pt: I didn't know what was (6.3)

3. S: okay can you tell me what you expected it to be when you order it?=

4. Pt: I didn't have any idea (H) (H)=

5. S: okay so you cho

6. Pt: now that, seven day er that, seven hour er something like that I (don't) I have no idea what that was.(1:0)

7. S: was it a salad?//or something=
8. Pt: umha
10. Pt: ye ... that was delicious.
11. S: okay, so you have no idea what it was going to be but it was good!
12. Pt: I just wanted to know I really do
14. Pt: an when I see something an that's something else I wanted to know what it was it was some kinda cake.
15. S: I'm not sure what that would be.
16. Pt: I don't either.
17. S: I'm trying to think of the term.
18. Pt: I ordered it just to see what it was like.
19. S: you like to try new things then?
20. Pt: well I like I was =
21. S: uha=
22. Pt: ya know I do have complaints I never never ordered syrup
23. S: okay, hot cereal is cold.
24. Pt: is always cold, now I don't think that it's your fault, cawes I know what your doing. I wish they'd let me come down
there an do something then I wish they'd
(0.9) take ma test an then they'd know
what's the matter with me. (0.3)

25. S: umha. (0.8)

26. Pt: they don't know what's the matter with
me. (1.0) ya know I've worked. (0.3) in,
pastry an different parts an: an it's
the lifting °er something. (0.7)+ that gives
me all the pain. (0.5)

27. Pt: an they, they haven't done anything like
that. (1.0) // they, put me on
but that darn thing ( 2.7 )
lifting like that=

28. S: umha

29. S: "uha. (1.0) + okay well that's all I wanted
ta ask. (0.5)

30. Pt: I I like ta (tape stopped)

#11, p. 9-10

In this example, the patient did not adhere to the student’s
set format. In turn #11, the student attempts to return to
the ritual but the patient does not comply and the attempt
fails. The student eventually terminates the conversation
unilaterally without completing the conversational ritual or
the conversation goals (as compared to other student-patient
conversations involving the same student and the same top-
ics).
In summary, the structure of student-patient talk is characterized by:

1. a question-answer sequence in which the student asks questions and the patient answers questions.
2. conversational topics are introduced by the student in a turn exhibiting a past and future or only a future part.
3. patient utterance turns generally contain only a present part.
4. the patient accepts topics introduced by the student but the student is not obliged to accept topics introduced by the patient.
5. topic closure within the conversation is unilaterally accomplished by the student.
6. topic closure at the end of the conversation or conversational closure may be unilaterally accomplished by the student or maybe negotiated between the student and the patient.

The structure of instruction in student-patient talk is characterized by:

1. the ritual nature of student utterances with respect to
   a) the topics of conversation.
   b) the order of topics introduced.
   c) the format of the student's utterances.
   d) the range of possible utterances allowed the patient.
2. the ritual nature of student utterances may be disrupted (a) by the student over time or (b) by the patient.

**Triads**

**Student-Preceptor-Patient Talk Structures**

One conversation was observed in which the participants included a student, a preceptor, and a patient. This
conversation took place in the patient's hospital room. Four characteristic structures of this talk will be discussed; (1) question-answer sequence, (2) topic introduction and closure, (3) conversational openings and closings, and (4) conversational repairs.

Question-answer Sequence:

The first characteristic, the question-answer sequence, involved two diads of the triad. One diad consisted of the student and the patient. Example #37 demonstrates the diad question-answer sequence.

(37) Student asks patient about possible problems related to a liquid diet given by naso-gastric tube.

S: okay. um have you had any problems with like diarrhea? or

Pt: no(mumbling)(Pt had neck surgery requiring excision of larynx therefore speaking is very difficult)

S: no or gas, er, nausea er vomiting?

Pt: no

In this type of question-answer sequence, the student asks the question and the patient answers the question.

The second diad which developed in student-preceptor-patient conversation consisted of the preceptor and the patient. The utterances of this diad were also question-answer
sequences. Example #38 illustrates this sequence.

(38) Preceptor asks patient about the liquid diet the patient is consuming via a naso-gastric tube.

P: are ya gettin(g) enough ta eat?.

Pt: as far as I know I'm not losing any weight

P: you're not losin(g) any weight? an you're not hungry?

Pt: naw.

Example #38 demonstrates that the preceptor asks the question and the patient answers.

Of the total number of 14 questions asked the patient, the student asked 6 and the preceptor asked 8. Of the total 19 non-patient turns, the student had 8 turns and the preceptor had 11. Thus, the preceptor had more conversational turns and asked more questions than the student.

Topic Introduction and Closure:

The second characteristic to be discussed is topic introductions and closings. Example #37 illustrates the topic introductions. Of the three parts of utterances, the student's first utterance exhibits a past part ("okay...um") and a future part ("have you had any problems with...like diarrhea"). The second student's utterance also exhibits a past and future part. Both turns by the patient ("no" and "no no") exhibit only a present part. This illustrates that
the student introduces the topic in the future part of the utterance and the patient accepts the topic with a present part utterance.

The topic introductions in preceptor-patient utterance are identical in structure to the student-patients utterance. Example #39 illustrates that the preceptor utterances contains a past part ("you're not losing any weight?") and a future part ("an you're not hungry?"), or only a future part ("are ya getting enough ta eat?"). The patient's utterances contain only a present part ("as far as I know I'm not losing any weight" and "naw"). As in student-patient utterances, this demonstrates that the preceptor introduces the topic in the future part of the utterance and the patient accepts the topic with the present part utterance.

Topic selection generally requires three turns in student-preceptor-patient conversations as it does in other classifications. This three-turn topic selection feature is exhibited in example #39. The preceptor introduces the topic in the first utterance. The patient accepts and elaborates the new topic introduced in the second utterance. In the third utterance, the preceptor accepts the patient's understanding of the topic and further elaborates.

As both examples #37 and #38 illustrate, topic closures are unilaterally determined by the student and the preceptor. The actual closure itself may be implied when an
utterance exhibiting only a future part introduces a new topic. Or, the topic closure may occur when the past part of a preceptor's or student's utterance is accomplished.

Conversational Opening and Closing:

The third characteristic of student-preceptor-patient talk structure is the conversational opening and closing. In this conversation the student opened the conversation which is illustrated in example #37. The conversational closing, however, was unilaterally accomplished by the preceptor as example #39 illustrates.

(39) Discussion is a continuation of example #38.

P: ok:kay(1.0)feel like you're gettin(y) too much(2.0)
Pt: no(0.4)

P: no(1.3)pretty good okay(0.7)an pretty good shape(1.2)okay(1.0)fine(1.6)all we wanted ta know

Conversational Repairs:

The last characteristic of this conversation concerns conversational repairs. The concept of conversational repairs by Schegloff (1977) was discussed in Chapter II. Examples #40 and #41 demonstrate conversational repairs.

(40) In both examples the student is asking the patient about the liquid (blenderized diet)
he is consuming.

S: um:a(1.0)have you been taking it all?(3.0)
Pt: taking everything what?(1.5)
P: are ya taking all your tube feeding?(0.5)

(41) S: no problems with tha(t)(1.5)um::m(0.6)do you like the(1.6)is this ah::h(1.8)I (hope) I don't know=
P: blenderized=
S: okay do you like being able to ah::m(1.0)have three different types a things like having the meat(1.0)an the vegetable(0.7)an the fruit in a separate cup?(1.0)

In example #40, the student's future part utterance is unclear to the patient resulting in a conversational error on the part of the student. The patient's utterance initiates the repair by repeating part of the student's turn ("taking everything...what"). The preceptor, in the third utterance, completes the repair by restating the entire question including the topic - tube feeding. In example #41, the student makes an implied error in her search for words by cut-off sounds ("with tha(t)"") and sound stretches ("um::m" and "ah::h") constitutes a repair initiation. The preceptor in the next utterance turn completes the repair of the error.
In example #40, (1) the error is made by the student; (2) the repair initiation is made by the patient; and, (3) the repair completion is made by the preceptor. In example #41, (1) the error is made by the student; (2) the repair initiation is made by the student; and, (3) the repair completion is made by the preceptor.

In summary, the characteristics of student-preceptor-patient talk structures include the following:

1. question-answer sequence
   a) the student asks questions and the patient answers questions.
   b) the preceptor asks questions and the patient answers questions.

2. topic introductions and closings
   a) the student unilaterally introduces topics and closes topics.
   b) the preceptor unilaterally introduces topics and closes topics.
   c) the patient accepts topic introductions and closings by the student and the preceptor.
   d) the selection of topics requires three utterance turns.

3. conversational opening and closing
   a) the student opens the conversation.
   b) the preceptor closes the conversation unilaterally.

4. conversational repairs
   a) the student makes the error.
   b) the student or the patient initiates the repair.
   c) the preceptor completes the repair.

Student-Preceptor-Instructor Talk Structure

Conversations involving a student, a preceptor and an
instructor were observed twice. The following illustration diagramatically displays how the conversation occurred.

Conversation A

I + S joined by P = \( I \leftrightarrow P \)

Illustration 2

As the illustration depicts in conversation A, the instructor and the student are participants in a conversation when the preceptor joins them. The turn-taking sequence resumes but between the instructor and the preceptor. A student turn occurs only rarely. Example #42 demonstrates an instance of student turn-taking as well as the turn-taking sequence of the instructor and the preceptor.

(42) Instructor, preceptor and student discuss the problem the student is experiencing with the clinical assignment.

I: okay.(0.5)I'm tellin(g) her one thin:ng.(0.6)
an you':re-tellin(g) -her- another and her mind's tellin(g) her something else.(0.4)
let's get ta what her mind's tellin(g) her cawes that's pro(ba)bly really what she
wants ta do.(0.7)

P: I can't.(0.4) I can't get out of her what she
what her mind's tellin(g) her to do=

I: I can.(0.4) that's alright.(0.5) I know M's
listening to that, I can..uh, okay, uh, I
been I been, I'm not too concerned about this
(0.4.) cawes you seem ta be.(0.5) moving along
nicely.(0.7) so it's okay.(0.5) but down deep in
your gut you want ta do something else, now
what is it, what'd ya think what.(0.5) what,
what, what's.(0.4) suppose ya could just, throw
all this away an start over which we're not
gonna ask ya ta do.(0.5)

S: (h) I hope not=

I: what would you, what would you have done?
what would you have rather done?

S: well I don't know.(0.8) see my whole problem
is +I don't know all that much about tube
feedings so I don't know what ta do with um=

The student utterance occurs when the student is referred to
directly or when a question is directed to her. On the other
hand, the instructor and preceptor take turns in sequence
and refer to the student as though she were not present.
The first three utterances of example #42 demonstrate this
feature.
Conversation B, as illustration 2 depicts, occurs between the preceptor and the student with the instructor joining them. The instructor's joining is acknowledged by the student and preceptor via a greeting as example #43 illustrates.

(43) Instructor joins preceptor and student.

I: hi=
S: hi=
I: hi Mrs. T. how are you?=
P: fine how are you?=
I: fine
S: [surprised ta see me here(h) pro(ba)bly.(1.0)]

#4, p. 4

Following the acknowledgement of the instructor's presence, the turn-taking between the preceptor and student resumes as though the instructor were not present. The first four utterances of example #44 illustrate the turn-taking between the preceptor and the student while the instructor is present.

(44) S: okay...fine
P: okay
I: did you fin(d) some patients?(0.5)
S: yes.(1.1)
I: okay.(0.5)
S: you know, you know what, happened though?, they turned out to be all males.(1.0)//I...(0.7)
that was, not my choice either.\(\text{\ldots}\)

Following the negotiated topic closure between the student and the preceptor (S: "okay...fine". P: "okay"), the instructor takes the turn-taking opportunity to introduce a new topic in an utterance containing only a future part. The student accepts the topic via the utterance exhibiting only a present part ("yes"). Thus, although the topic of the preceptor and student by the instructor is acknowledged, the preceptor-student turn-taking resumes. The only turn utterance sequence including the instructor occurs when she introduces a topic directed toward the student following a negotiated topic closure between the student and the preceptor.

The second characteristic structure of student-preceptor-instructor talk to be discussed involves turn utterances which reflect a difference of opinion between the conversational participants. For the purpose of this discussion, the term conflict will be used to describe conversational occurrences in which one participant disagrees with another. This conversational phenomena occurred between the preceptor and the instructor as example #46 illustrates.

(46) Discussion involves the manner in which tube-feedings are given to the patient.

I: ye ya-give-it too fas\(t\), ya give it too col\(d\)=

The instructor states that the preceptor gives the patients tube feedings which are too cold, too much and given too fast. The preceptor disagrees with the instructor that the tube feedings are too cold or that they are given too fast. In the last utterance the instructor acknowledges the preceptor's position ("then they aren't dumping okay") and introduces a new topic, ("I think if ya work with...give her some tube fed patients...").
Example #46 also illustrates the conflict phenomenon.

(46) Discussion focuses on the problem the student is encountering in performing her clinical activities. Instructor's "you" refers to student.

I: you're not ya-know you're not seeing—why am I doing all this for you're doing this for when you go out an you have patients to(0.4) instruct(0.7) who're gonna spend the rest a their lives with this tube feeding, you wantta know a awful lot about it(0.5) if-th-if-tha-if that helps ya fine if it doesn't you're gonna have ta a::a discover(0.6) for your self(0.4) why you're-doing-this-an-it'll then, your data will start ta sing to you(0.5)

P: I(0.4) don't think(0.5) that(0.6) patient has ta go home on this(0.7) in this(0.4) for this ta be(0.4) valuable=

I: well okay I'm trying I'm trying to this type a diet be-cause these patients are on it li:ke(0.5).a month maybe two months here=

I: okay(1.0)

P: so it's still, it's still the value of this type of a(0.6) diet is still(0.7) present here ev-en though they aren't=

I: well well the work she's doing is appli-cable to any kind of a(0.4) any kina of
The instructor states that the student is encountering a problem because the patient she is seeing will not be using a tube feeding at home. The preceptor disagrees with the implication that if the patient isn't going to be eating via a tube feeding at home, the clinical experience isn't worthwhile. In the last utterance, the instructor acknowledges the preceptor's position and introduces the new topic - the magnesium content of Ensure (a commercially prepared tube feeding).

In summary, student-preceptor-instructor talk structures are characterized by:

1. conversational turn-taking occurs between only two of the three participants at a time. The turn-taking predominantly occurs between the same two participants.

2. conversational conflict occurs between the instructor and the preceptor. The conflict is discontinued when the instructor introduces a new topic.

Summary

Chapter IV has presented, in a systematic way, the observations of five classes of clinical instruction
conversations. The conversational classes were:

1. student-instructor conversations
2. student-preceptor conversations
3. student-patient conversations
4. student-preceptor-patient conversations
5. student-preceptor-instructor conversations

The first three classes of conversations represent diads; and, the last two represent triads.

Chapter V draws upon the observations presented in this Chapter to:

1. develop hypotheses concerning clinical instruction of medical dietitians.
2. present conclusions and recommendations concerning the ethnomethodological technique of conversational analysis.
References


CHAPTER V

HYPOTHESES AND RECOMMENDATIONS

Introduction

This Chapter discusses the hypotheses and recommendations based on the results of the study. These hypotheses and recommendations are related to two areas of concern, (1) clinical instruction, and (2) conversational analysis.

Chapter V consists of five segments. The first three sections are devoted to clinical instruction and hypotheses, related research and future research. The fourth and fifth sections discuss the conclusions and recommendations related to the effectiveness of conversational analysis.

Clinical Instruction

This section of Chapter V discusses the findings of this study and associated research. This discussion has been organized into six segments, each featuring a hypotheses generated by this study.
Hypotheses I

The first hypotheses deals with conversational control exhibited by participants and its relationship to research concerning social power. Sergiovanni and Carver (1975) state that power is the potential capacity to effect movement toward a goal. Sergiovanni and Carver believe, that within the parameter of this definition, the terms "power" and "authority" can be used interchangeably. In this discussion, the term "power" will be used so that terminology will remain consistent with that of French and Raven.

According to French and Raven (1968) there are five sources of power. It is important to understand that in French and Raven's notion, power is given to an individual via the perceptions of others. Power does not originate from within the individual. In other words, the subordinate, through his perceptions, gives the superior the capacity to have power over him. Therefore, the source of power originates within the subordinate not the superior.

According to French and Raven there are five bases of social power.

1. **Reward** - the subordinate perceives that the superior can withhold or increase rewards.

2. **Coercion** - the subordinate perceives that the superior can distribute punishment.

3. **Legitimate** - the subordinate perceives that the superior, by virtue of his position and status
within a duly constituted hierarchy, has the right to do as he does and expect what he expects.

4. **Referent** - the subordinate perceives the superior as a desirable and appropriate human model and wants to be mutually perceived, thus demands are accepted.

5. **Expert** - subordinate perceives that the superior possesses relevant expertise and knowledge.

Table 2 illustrates the application of this concept of power to the diad participants of this study. In this table the relative social power of each participant of the diads is estimated. As Table 2 indicates in student-instructor talk, the instructor is perceived as having relatively greater social power. In student-preceptor talk, social power appears to be distributed relatively evenly. In student-patient talk, the student is perceived as having slightly more social power than the patient.

The second definition important to this discussion is that of conversational control. Conversational control is the capacity of a conversational participant to determine the direction and length of talk by:

1. conversational mechanisms.
2. possessing the greater pool of topic knowledge.

The first aspect of this definition is based on the characteristics of conversational structures discussed in
Table 2
Aspects of Conversational Control
by Class of Talk

<table>
<thead>
<tr>
<th>Control Characteristic</th>
<th>Student-Instructor</th>
<th>Student-Preceptor</th>
<th>Student-Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>ask questions</td>
<td>instructor</td>
<td>student</td>
<td>student</td>
</tr>
<tr>
<td>introduce topics</td>
<td>instructor</td>
<td>student</td>
<td>student</td>
</tr>
<tr>
<td>close topics</td>
<td>instructor</td>
<td>student + preceptor</td>
<td>student</td>
</tr>
<tr>
<td>close conversation</td>
<td>-</td>
<td>student + preceptor</td>
<td>student or student + patient</td>
</tr>
<tr>
<td>pool of knowledge</td>
<td>instructor</td>
<td>preceptor</td>
<td>patient</td>
</tr>
</tbody>
</table>

Chapter IV. Thus, conversational control is the capacity to determine the direction and length of talk through the following conversational mechanisms:

1. asking questions in a question-answer sequence.
2. introducing conversational topics.
3. closing conversational topics.
4. closing conversations.

The second aspect of conversational control, discussed in Chapter IV under instructional characteristics, involves the nature of the question-answer sequence. The observation was made that there were two types of question-answer sequences that are based on which participant had the greater pool of
topic knowledge. For example, in student-instructor talk, the instructor asked the questions and also had the greater pool of topic knowledge as compared to the student. On the other hand, in student-preceptor and student-patient talk, the student asked the questions but the preceptor and the patient had the larger pool of topic knowledge as compared to the student. Therefore, in student-instructor talk, the instructor asks questions to which she knows the answer in order to make information evident. The student asks questions so their pool of topic knowledge will begin to approach that of the other participant. However, the other participant, by answering, carefully controls how much knowledge or information the student may gather. Therefore, the participant, who has the greater pool of knowledge, exhibits control of this component of conversational control.

In summary, conversational control is determined by:

1. asking questions in a question-answer sequence.
2. introducing conversational topics.
3. closing conversational topics.
4. closing conversations.
5. possessing the larger pool of topic knowledge.

This aspect is weighted heavier than any one of the first four aspects alone.

Table 3 illustrates the observations concerning conversational control for each diad. As Table 3 indicates in student-instructor talk, the instructor exhibits
Table 3
Estimate of Social Power of Participants
by Conversational Class

<table>
<thead>
<tr>
<th>Class of Talk</th>
<th>Sources of Social Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student-Instructor Talk</td>
<td>Student preceives that the instructor has the capacity to reward and coerce (via grades), has expertise and legitimacy (via position). The instructor preceives that the student has legitimate power as a consequence of being a student at a teaching institution.</td>
</tr>
<tr>
<td>Student-Preceptor Talk</td>
<td>The student preceives that the preceptor has expertise and legitimate power. The preceptor preceives that the student has legitimate power as a student at a teaching institution.</td>
</tr>
<tr>
<td>Student-Patient Talk</td>
<td>The student preceives that the patient has legitimate power as a client of services. The patient preceives that the student has expertise and legitimate power as a member of the medical team.</td>
</tr>
</tbody>
</table>
conversation control. In student-preceptor talk, conversa-
tional control is distributed relatively evenly between the
student and preceptor. In student-patient talk, the student
demonstrates slightly more conversational control than the
patient.

In summary, the results of this study and other related
research seem to indicate a relationship between the conver-
sational control exhibited by the conversational partici-
pants and the relative social power of the participants.
Therefore, the following hypothesis is generated:

Hypothesis I: Conversational control of diads in
clinical instruction of medical dietitians reflects
the relative social power of the participants.

Hypothesis II

Hypothesis II deals with the three-part turn structure
referred to in Chapter IV and its relationship to conversa-
tional control and conversational topic. A recent ethno-
methodological study conducted by Elaine Litton-Hawes (1976)
also investigated the structure of turns. This study fo-
cused on discourse analysis or conversational analysis of
initial interviews between a patient and a physician. The
results of this study indicate that although a three-part
structure was occasionally observed in doctor's turns, it
often took an abbreviated form. Likewise, patient's turns
often displayed only a two-part structure; one relating to
the past turn and one occupying the present turn.
Furthermore, Litton-Hawes (1976) found that the abbreviated conversational turn of the doctor may be especially problematic for the patient when the doctor implies a new topic. If the physician’s turn omits the past part of the turn structure, the patient has no way of knowing how their previous turn was heard. The physician, apparently, is not obligated to conversationally associate new topics to old 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 relationship 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 (Litton-Hawes, p. 80).

The observations of this study are similar to those of Litton-Hawes. In the student-instructor diad, the instructor often omitted the past turn part when introducing a new topic. The same utterance structure was found in student-preceptor talk, for the student and, in student-patient talk for the student. In other words, the conversational participant introducing a topic did not employ a three-part turn structure which relates the new topic to the old topic. In addition, Table 2 points out that the aspects of conversational control were unevenly distributed between the participants of each class of conversations, particularly
student-instructor conversations and student-patient conversations.

Therefore, Sacks' (1974) concept of a three-part turn structure does not apparently apply to student-instructor, student-preceptor or student-patient talk as it did not for medical interviews. Although Sacks stated that the three-part turn structure was generalizable to a variety of situations, his observations were made in informal conversations having more than two participants. Litton-Hawes states that perhaps where one participant in a conversation exercises more control than the other, the three-part turn structure does not apply. In addition, this study identified that it may be the intent of the conversational participant which has a bearing on the use of the three-part turn structure. For example, in student-instructor talk, when the intent is to build a generality, the relationship between topics to formulate the generality is crucial. Whereas, in student-preceptor talk, the topics of the practical aspects of clinical instruction are somewhat discrete and there is no intention to formulate a generality. Therefore, in student-preceptor talk, the three-part turn structure (to relate new topics) is not crucial.

In summary, the results of this study and other related research seem to indicate a relationship between uneven conversational control by participants and the absence of three-part turn structures. This relationship may also
be influenced by the intent of the conversational participants introducing topics. Therefore, the following hypothesis is generated.

Hypothesis II: Absence of the three-part conversational turn structure reflects the unequal distribution of all aspects of conversational control between participants.

Hypothesis IIa: This relationship is influenced by the intent of the conversational participants in introducing topics.

Hypothesis III

Hypothesis III focuses on the triads observed during this study and the research concerning triads and coalition formation. The triad has been a phenomenon of interest to sociologists since 1890 when George Simmel began to investigate triads as social systems. In the 1950's, social psychologists began to systematically study triads both in laboratory situations and in real-life settings.

Caplow (1968) defines a triad as a social system containing three related members in a persistent situation. Every triad has three relationships and three members, the only social group which has an equal number of members and relationships. The three members can be called A, B, and C. The three relationships can be denoted as AB, AC, and BC. The most important feature of a triad is its tendency to divide into coalition of two members against the third.

The appearance of particular coalitions can be predicted with considerable accuracy if the
relative power of the three members be known. This procedure involves a find of social geometry, for the occurrence of a coalition cannot be predicted from previous experience of that particular triad, but must be derived directly from the triadic structure. (Caplow, p. 2)

W. Edgar Vinacke and Abe Arkoff, among others, have studied coalition formation and have developed predictive models based in the relative power of the triad members. Particular coalition predictions of Vinacke and Arkoff will be discussed later in relationship to the triads and coalitions observed in this study.

There are three situations which affect coalition prediction. These situations are:

1. continuous situations in which the triad members are permanently related to each other within the larger social system.

2. episodic situations in which located within a permanent organization, however, the goal of the coalition is to secure an advantage in a contest governed by rules (in a legislature, for example).

3. terminal situations in which the triad exists unwillingly and the goal is to prevent further triad formation.

A second feature of a triad is what Caplow calls the catalytic effect. Simply stated, each pair of relationships in a triad may occur alone or in the presence of the third member. However, the presence of the third member always
modifies the relationship of the other two.

The triads and the coalitions observed during this study will be described using the features mentioned above. The student-preceptor-patient triad which consisted of one conversation was an episodic situation. Applying the definition of conversational control discussed earlier, the student and preceptor have nearly equal conversational control which is superior to the control exercised by the patient. However, the feature of conversational repairs suggests that the preceptor exercises more conversational control than the student. Schegloff (1977) states that there is a preference for self-repair in adult conversation. In this student-preceptor-patient talk, there was a preponderance of other repair of the student's errors by the preceptor. This indicates that the preceptor exhibited more conversational control than the student.

Therefore, it appears that the relative conversational control from high to low is the instructor (A), the student (B), the patient (C). If one assumes that conversational control reflects the social power of the participants, as proposed by Hypothesis I, relative conversational control can be used to predict coalition formation. Using the work of Vinacke and Arkoff (1957) in predicting coalition formation, the coalitions formed should be AC or BC. Both coalitions, instructor-patient and student-patient indeed formed as the conversational results reported in Chapter IV denote.
The second class of triads observed consisted of two conversations involving a student, a preceptor and an instructor. In one of the conversations observed the instructor joined the student and preceptor. The instructor occasionally participated in the conversation directing her comments to the student. Although the data available is not sufficient to make estimates of the relative social power, some comments can be made. For example, the intrusion of the instructor into the student-preceptor was tolerated and immediately acknowledged which possibly indicates that the instructor is perceived by the student and the preceptor as powerful. Since the student possesses the smallest knowledge pool, the high to low power structure is possibly instructor (A), preceptor (B), student (C). This relationship fits the Vinacke-Arkoff type 5 triad in which the predicted coalitions are AC and BC. The conversations did indicate that both these coalitions formed.

The second conversation observed in this class is somewhat unusual. Conversational conflict occurred in this conversation between the instructor and the preceptor. Occasionally, the instructor directed her comment to the student in an effort to support her own position. Only then did the student participate in the conversation. If one assumes the same power relationship as in the first student-preceptor-instructor conversation, it appears that there is a weak coalition formation between the instructor and student, AC.
This is a predicted coalition of the Vinacke-Arkoff type 5 triad.

The brief discussion above illustrates the need for additional research of triads and coalition formation in clinical instruction. No doubt coalition formation in triads have an impact on clinical instruction talk and activities. The following hypothesis may be a starting place to continue investigating this phenomenon.

Hypothesis III: Conversational structures reflect coalition formation in triads in clinical instruction of medical dietitians. Coalition formations in clinical instruction can be predicted if the relative conversational control (which reflects relative social power) of the participants of the triad is known.

Hypothesis IV

Hypothesis IV focuses on the two methods of instruction described in Chapter IV. The first method which was used by the instructors can be characterized as a generality or theoretical principle which could be transferable to other similar situations. The instructor emphasized the transferability of the generality by stating that the student will find the generality useful when she is working at a small hospital after graduation. In addition, this method focuses on process by which the student obtained the product as well as the product itself.

The second instructional method described in Chapter IV was that of the preceptor. This method can be characterized
as a practical method focusing on details of how to perform clinical activities. This method is specifically concerned with "how to do" clinical acts.

Thus, the instructor and the preceptor apparently do not use the same method of instruction nor is the focus of the methods the same.

Hypothesis IV: The instructional method of instructors (generality-building) during clinical instruction is different from the instructional method of preceptors (pragmatic).

Hypothesis V

Hypothesis V deals with the conversational conflict observed in some conversations and the indexicality of rules. Conversational conflict was observed in conversations involving an instructor and a preceptor. The basis of this conflict is somewhat related to the instructional methods of instructors and preceptors. The instructor takes a theoretical view of a clinical situation and the preceptor takes a practical view.

For example, the instructor, upon being confronted with a tube feeding, calls upon scientifically developed criteria to guide her actions. Scientifically developed criteria are by nature, measurable, objective, and unchanging. On the other hand, the preceptor, upon confronting a tube feeding situation, calls upon experientially developed criteria to guide her actions. Experientially developed criteria are, by nature, subjective, changeable and, not necessarily
measureable. The instructor's orientation makes the tube feeding a thing; and, the preceptor's orientation makes the tube feeding an experience. The conflict occurs as consequence of the nature of the different criteria used. One is based on science and one is based on experience.

Another aspect of this phenomenon of conflict is related to Mehan (1974) concept of the "indexicality of rules". The scientific criteria of the instructor may be thought of as a rule or principle. Mehan points out that rules are indexical, that is, regardless of how complete and detailed the rule may be, it is never able to completely account for all situations in which they must be applied. Therefore, the specific situation further defines and adjusts the rules. Specifically this means that the instructor applies the unadjusted rule to the situation. The preceptor, more familiar with specific applications, applies an adjusted or redefined rule. Specifically, the practical considerations, in terms of which the preceptor works, are indeed "indexical". Thus, the practical considerations demand the preceptor's particular judgment in each instance. These judgments, then, are not generalizable; but rather, they rest on the peculiarities of each case - history of the patient, medical priorities, etc. On the surface, the rules of the instructor and preceptor may not appear to be the same, and thus, a conflict arises.
This results because the instructor and the preceptor are viewing the phenomenon from different angles. These observations have, therefore, generated the following hypothesis.

**Hypothesis V**: Conversational conflict between instructors and preceptors is caused by (1) the indexicality of rules or principles and (2) the scientific criteria of instructors and the experiential criteria of preceptors.

**Hypothesis VI**

This hypothesis deals with the two components of clinical instruction identified by this investigation. The observation that student-patient talk had a ritualistic character was discussed in Chapter IV. As the ritual nature of student talk lessened, two components became evident. For the purpose of this discussion, these components will be called conversational competence and content competence.

Content competence can be defined as the pool of skills and knowledge of food, human nutrition and medical dietetics. Conversational competence can be defined as the pool of cultural skills and knowledge of verbal interaction. The purpose of clinical instruction, then, is to achieve an interweaving of these two complex competencies. Since the clinical practice of the medical dietitian is conducted chiefly through verbal interaction, the student must be competent in the cultural skills and knowledge of verbal interaction. Within the milieu of the verbal interaction of clinical
dietetics is embedded the content or the skills and knowledge of food, nutrition and dietetics.

Confusion is created when content competence and conversational competence are assumed to be one. For example, in the student-preceptor-patient talk, the student made many conversational errors which were repaired by the preceptor. The consequence of this conversational problem was that the student often did not complete an entire turn unaided. As a consequence, content was not demonstrated in her incomplete turn. Thus, conversational competence is necessary in clinical instruction to demonstrate content competence. In this particular student-preceptor-patient talk occasion, nothing can be said of the student's pool of content skills and knowledge. All that can be said is that the conversational problems of the student inhibited her demonstrating whether or not she has and is able to apply the knowledge and skills of food and nutrition.

Another conversational example further illustrates the relationship between conversational competence and content competence. One of the student-patient conversations involved the student taking a diet history from a patient who had diabetes mellitus. In diabetes, the caloric content and distribution of calories among fat, protein and carbohydrate is an important aspect of treatment. During the student-patient talk, the student asked the patient what she usually ate for lunch. The patient stated that she ate a sandwich
and fruit. The student further questioned the patient about the types of fruits. The patient said that she ate one exchange serving (serving according to the diabetic exchange system) of either diatetic canned fruit or fresh fruit. The student then proceeded to ask about dinner. The composition of the lunch sandwich was not introduced during the remaining conversation. The content question which arises is, does the student understand that the caloric content and distribution of calories of a sandwich may vary greatly depending on the sandwich composition; whereas, the caloric content and caloric distribution of fruit regardless of type varies little? This content question concerning the student's pool of knowledge and skills could only arise because the student's conversational competence was such that content competence (or lack of it) could be demonstrated.

Conversational competence is a necessary and facilitating component of clinical instruction. An analogy can be drawn between clinical instruction and IQ testing. If an individual who cannot read or write is given a standard IQ test, the test results will probably indicate that the person has a low IQ level (setting aside the question whether such test do indeed measure intelligence). However, implicit in this testing situation is the reading and writing competence required to demonstrate intelligence or IQ level. Therefore, this testing situation involves two aspects, (1) the reading and writing competence which is first necessary
in order to demonstrate, (2) intelligence or IQ level.
Clinical instruction also involves two aspects, (1) conver­
sational competence which is first necessary in order to
demonstrate, (2) content competence. If the student does
not have conversational competence, nothing can be said of
their content competence just as nothing can be said of the
individual's IQ level in the previous example.

Hypothesis VI: Conversational competence is
necessary to demonstrate content competence in
clinical instruction of medical dietetic stu-
dents.

Recommendations

This section of Chapter V discusses some specific
recommendations for clinical instruction which are out-
growths of this investigation. Some of these recommenda-
tions are related to the hypotheses discussed in the pre-
vious section and, therefore deserve further research em-
ploying both ethnomethodology and other traditional meth-
odologies.

1. It appears that instructors and preceptors use dif-
ferent instructional approaches which have different instruc-
tional intents. It is likely that medical dietetic students
need both instructional approaches in order to know and do
clinical activities. It is the recommendation of this in-
vestigator that the nature of these two approaches suggest
that they are best presented to the student by two different
individuals.
2. The second recommendation is related to the first. It is not necessary and, may actually be unwise, to inform the preceptor of the nature of her instructional approach and that of the instructor. An analogy can be drawn between the structure of language and the structure of instruction. A child may typically use language that is grammatically correct without ever knowing the structure of grammar. In fact, being made aware of the structure rules of grammar may actually create problems. The child, knowing the rules, may attempt to compare his language (before he says it) to the rules. The result may be an uneven flow of language and even more grammatical errors. For the purpose of clinical instruction, then, the preceptor's awareness of the structure of her instruction is not crucial. If the preceptor were informed of her instructional approach and that of the instructor, she may attempt to compare the two approaches, attempt to change hers or intellectualize about the approaches, all of which may be ultimately unproductive to clinical instruction.

3. Coalition formation in triad situations appears to be inevitable. Knowing this, it is the recommendation of the investigator that instructors and preceptors be acquainted with the ramifications of coalition formation in clinical instruction activities. There are, no doubt, situations in which triads are beneficial; but, there are also situations in which they are not. If it is the instructor's
or preceptor's intention that the student and patient participate in a conversation, it is important for her to know that her mere presence will modify that conversation. Indeed, one of the predicted coalitions is the instructor or the preceptor and the patient, excluding the student. This coalition is contrary to the original instructional intention.

4. The concepts of conversational competence and content competence presented in this discussion implies that these aspects warrant instructional attention and evaluation. Conversational analysis is judged to be a potent method for differentiating between conversational competence and content competence. Future work in this area may identify certain crucial aspects or portions of conversations which will make conversational analysis feasible for this purpose. In addition, conversational analysis of transcripts of clinical instruction can be useful in eventually defining evaluation criteria for assessment of clinical performance. Transcripts, without analysis information, may also be useful as an educational tool to introduce students to the conversation of clinical practice.

At the present time the content of medical dietetics is often assessed through multiple choice written examinations. It is the recommendation of this investigator that in addition to these examinations, a more clinical-like assessment of a student's pool of knowledge and skills be implemented.
For example, in the multiple choice situation which emphasizes convergent thinking, the range of possible alternative has already been identified for the student. All that is required of the student is to make a decision (a choice or a guess) between the alternatives. A more clinical-like assessment, or divergent approach, might ask the student to identify the alternatives of the situation and choose one. This might also be related to a time limit. In clinical situations students often must identify alternatives and make a decision from one sentence to the next. Video taped situations typically encountered in the clinical environment may be an excellent technique by which clinical situations could be present to students for assessment of the student's pool of content.

Future Research

The previous two sections of Chapter V provide numerous suggestions for future research in clinical instruction of medical dietitians. Some additional research questions are:

1. Of the five components of conversational control, are some more crucial, and therefore, can be weighted in some way?

2. Are there instances of the three-part turn structure occurring in clinical instruction? How are these different from instances not demonstrating a three-part structure?
3. Can instances be identified, in advance, when triad and coalition formation are supportive of instructional intent? Are there certain instructional objectives which are most compatible with triad and coalition formation?

4. Can an evaluation strategy (criteria, etc.) be developed which assesses conversational competence, and content competence, separately?

The only additional suggestion for future research is to investigate clinical instruction as it is used in the education of other health professionals. This is necessary because ethnomethodology and conversational analysis are not an inferential method or analysis technique.

**Conversational Analysis**

The problems associated with conversational analysis discussed in Chapter II cannot be resolved in one study. However, as each study wrestles with those problems new insights about conversational analysis will come to light.

**Conclusions**

The first two portions of this Chapter discuss in detail the results of this study which used conversational analysis. Many of the hypothesis presented concerning clinical instruction were unknown prior to this study. Many of the aspects of clinical instruction presented could not
have been identified nor investigated by traditional experimental or clinical methods. By virtue of the quality, the scope and the nature of the results of this study, it is apparent that conversational analysis was well suited to the goals of this study. Based on this study it is likely that conversational analysis will continue to have utility in investigating substantive issues in many disciplines.

Another conclusion about conversational analysis deals with the analysis procedures. Throughout the conversational analysis procedures, the investigator must take a perspective similar to that of an anthropologist observing a foreign culture. This point was made by Litton-Hawes (1975). Mechanisms which were helpful in achieving this perspective included, (1) taking notes in the margins of the transcripts and (2) outlining observations in brief notes which were separate from the transcripts. This process of recording via writing, organized the observations being made so that patterns eventually emerged. Patience and time, however, is required to repeatedly review notes and outlines of observations before patterns begin to emerge.

Another important consideration of investigators, planning to use conversational analysis, is the level and scope of the problem. Conversational analysis takes a microscopic view of verbal interaction. Therefore, it is crucial that the problem to be investigated is defined and limited so that conversational analysis is appropriate.
Investigating a problem which is broadly defined sacrifices depth of investigation for scope when applying a microscopic technique such as conversational analysis.

Evidentiality will always be a problem. Investigators using conversational analysis must continually cope with lack of agreed-upon conventions for gathering and analyzing data. This can be an advantage in that it challenges the investigator. However, it is also a disadvantage in that unconventional procedures may be judged unacceptable by the scientific community. In addition, lack of terminology, which uniformly conveys specific conversational analysis meaning, complicates the discussion and description of the data gathered in such studies.

Another ever present evidentiality concern is validity. Validity was dealt with in this study in the same manner as it has been in other ethnomethodological studies. Throughout this study, data, patterns and structures were presented to (1) ethnomethodologists, (2) students of ethnomethodology and (3) lay people. These groups were then asked if the data supported the patterns and structures from their viewpoint. On some occasions, only raw transcripts were discussed to identify patterns and structures from fresh points of view. This process was most beneficial and did result in the addition and deletion of tentative patterns and structures.
Conversational analysis is at a stage of development similar to that of most statistical procedures before the development of computers. No doubt the tedious and time consuming procedures of conversational analysis, such as transcribing and coding, limit the application of conversational analysis. Although conversational analysis by its nature will remain a micro-analysis technique for investigating talk, technology may eventually enlarge the utility of this technique. Just as the computer put complex statistical analysis procedures within the reach of many investigators, technology may also put conversational analysis within their reach.

Recommendations

There are four recommendations for those considering the use of conversational analysis.

1. The qualities and properties of conversational analysis should be matched with the attitude of the investigator. The investigator must feel confident and comfortable with unstructured analysis procedures and ambiguity.

2. Problem delineation is crucial to the most effective use of conversational analysis. While delineating the problem, the investigator must keep in mind the microscopic nature of conversational analysis. The scope of the problem must also be matched to the time and resource limitations of the investigator.
3. Conversational analysis requires time and patience. It is impossible to know in advance how long it will take to discover the structures and patterns, underlying the talk, that are of interest to the investigator.

4. The current procedures for validation require the aid of individuals knowledgeable and not knowledgeable in the methodology and analysis technique. Therefore, investigators must have a consortium of individuals willing to peruse, review, and validate transcripts and patterns or structures.
References


Schegloff, E. Conversational Repairs. Lecture at The Ohio State University, Columbus, Ohio. February 18, 1977.

Appendix A
1) Describe the requirements for a subject population and explain the rationale for using in this population special groups such as prisoners, children, and mentally disabled or groups whose ability to give voluntary informed consent may be in question.

The subject population includes:

1. Six Medical Dietetic student volunteers.
2. Three Medical Dietetic volunteers instructors (senior instructors).
3. University Hospital dietitians (volunteers) whose responsibility includes that area of University Hospital in which the six Medical Dietetic students are assigned.
4. Volunteer adult patients of University Hospital who are assigned or selected by the six students or the three instructors. This is the typical process which occurs in the educational program of Medical Dietetics.

Informed consent will be obtained from all participants. The rationale for using this population is that clinical instruction, the phenomena being investigated, is a process of interaction which occurs among the individuals of the above groups.

2) Describe and assess any potential risks—physical, psychological, social, legal or other—and assess the likelihood and seriousness of such risks. If methods of research create potential risks, describe other methods, if any, that were considered and why they will not be used.

Any patient information such as diagnosis, sex, etc. will be held in strict confidence and known or recorded only by investigator. Cassette recorded interaction will be held in confidence during the study and tapes will be destroyed upon study completion. Transcripts of interaction made from tapes will be held in confidence and the identity of the participants will be coded. This code will be known only to the investigator. The likelihood of potential physical, psychological, social or legal risks are minimal or non-existent. The only risk that can be envisioned is the exposure of confidential information. The procedures of coding, tape destruction and transcript confidentiality will effectively protect against violation of confidentiality.
The point should be emphasized that the participants per se are not the focus of this investigation, but the interaction episodes occurring among them within the process of clinical instruction.

3) Describe consent procedures to be followed, including how and where informed consent will be obtained.

The consent procedures to be followed include:

1. The nature of this study will be explained to the Medical Dietetic students. AVTV consent forms will be reviewed and signed by students prior to study.
2. The nature of this study will be explained to Medical Dietetic instructors. AVTV consent forms will be reviewed and signed by instructors prior to study.
3. The nature of this study will be explained to the selected volunteer University Hospital staff dietitians. AVTV consent forms will be reviewed and signed by volunteer dietitians.
4. Permission to tape conversation with patient will be obtained by Medical Dietetic students prior to interview with patient. Immediately following the interview, the investigator will explain the nature of this study to the patient. The investigator will request AVTV consent forms be reviewed and signed by patient. If the patient selects not to participate in the study, the cassette tape will be destroyed immediately.

4) Describe procedures (including confidentiality safeguards) for protecting against or minimizing potential risks and an assessment of their likely effectiveness.

This point has been discussed in section 2.

5) Assess the potential benefits to be gained by the individual subject, as well as benefits which may accrue to society in general as a result of the planned work.

The direct potential benefits gained by the individual participants will likely be minimal except:

1. students will have the opportunity to participate in ongoing research and become knowledgeable in
in this research methodology.
2. instructors will have the opportunity to partici­pate in ongoing research and gain knowledge and insight into clinical instruction.

The future benefits to society via a better understanding of the nature of learning in general and clinical instruction specifically include:

1. better understanding of the learning process.
2. better understanding of the learning process in a reality environment.
3. improvement in the process of clinical instruction which will benefit students, instructors, patients and institutions.

This investigator hopes that the findings of this study will be utilized to improve the use of clinical instruction and the education of professionals and paraprofessionals and thus contribute to the improvement of health of society.

6) Analyze the risk-benefit ratio.

As discussed in the previous sections, the risk-benefit ratio is expected to be heavily weighted on the benefit side with few, if any, risks.
Appendix B
This is to inform you that your research proposal entitled "Conversational Analysis: An Ethnomethodological Approach to Clinical Instruction" has been reviewed in accordance with current policy regarding clinical investigations. The Research Committee and the Executive Committee of the College of Medicine approve this application.

You are reminded that you must promptly report any problems to the Research Committee, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Approved:

[Signature]

Executive Committee
College of Medicine

Approved:

[Signature]

Chairman, Research Committee
Appendix C
The Ohio State University
University Hospitals

Research Involving Human Subjects
Consent to Serve as a Subject in Research

Behavioral and Survey Research Form

I consent to serve as a subject in the research investigation entitled: ETHNOMETHODOLOGY: AN APPROACH TO CLINICAL INSTRUCTION.

The nature and general purpose of the research procedure have been explained to me. This research is to be performed by or under the direction of Dr. Robert Bargar, Ph. D., who is authorized to use the services of others in the performance of his research.

I understand that any further inquiries I make concerning this procedure will be answered. I understand my identity will not be revealed in any publication, document, recording, video-tape, photograph, computer data storage, or in any other way which relates to this research. Finally, I understand that I am free to withdraw my consent and discontinue participation at any time following the notification of the Project Director.

Signed ________________________
(Subject)

Date __________________________

A.M. __________________________ P.M.

Witness - (Auditor)

Maria L. Steinbaugh
Investigator
Appendix D
June 23, 1976

Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43212

Dear Dr.

This letter is to acquaint you with a study entitled "Ethnomethodology: An Approach to Clinical Instruction". I am a graduate student in the College of Education and Allied Medical Professions at Ohio State University and this research study is in partial fulfillment of a Ph.D. This study has been approved by the Ph.D. Advisory Committee and by the Human Experimental Research Committee of Ohio State University Hospital.

The focus of this study is the clinical instruction of Medical Dietetic students. This phenomena has been described as the interaction which occurs between and among the student, the clinical instructor, the staff dietitian and the patient for the purpose of providing nutritional care. It is this interaction which I will be coding, describing and analyzing. The methodology best suited for this study requires the audio recording of interaction.

The guidelines set forth by the Human Experimental Research Committee suggests that approval for voluntary patient participation be gained from the staff physician. It should be noted that patients asked to participate in this study will be those contacted by Medical Dietetic students in the course of their normal activities to provide nutritional services. Participating patients will sign the standard AVTV form, an example of which is enclosed. Also enclosed is the information form provided by the Human Experimental Research Committee which may answer additional questions.

In summary I would appreciate your permission to approach patients under your care for their voluntary participation in the study detailed above. If this is agreeable to you, please sign the attached form.

Thank you for your cooperation and time.

Sincerely,

Maria L. Steinbaugh
I, Dr. ______________________, give permission for patients under my care to voluntarily participate in the study entitled, "Ethnomethodology: An Approach to Clinical Instruction", conducted by Maria L. Steinbaugh.

____________________
signature

____________________
date
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