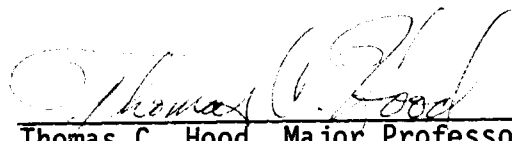


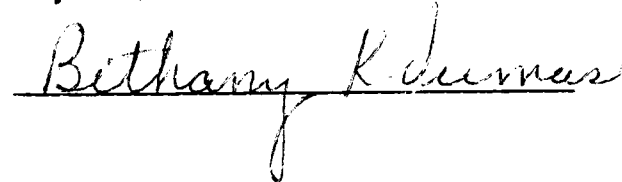
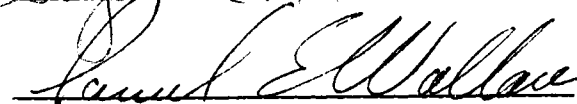
To the Graduate Council:

I am submitting herewith a dissertation written by Stephen B. Groce entitled "Medical Interviews, Treatment Decisions and the Social Construction of Reality: An Analysis of Doctor-Patient Communication." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Sociology.



Thomas C. Hood, Major Professor

We have read this dissertation and
recommend its acceptance:



Accepted for the Council:



Vice Provost
and Dean of the Graduate School

MEDICAL INTERVIEWS, TREATMENT DECISIONS AND THE
SOCIAL CONSTRUCTION OF REALITY: AN ANALYSIS OF
DOCTOR-PATIENT COMMUNICATION

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Stephen B. Groce
August 1986

This dissertation is dedicated to my mother, Myrna B. Groce,
and in loving memory of my father, Aaron C. Groce

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Although it is impossible to single out the many people who contribute to the formulation and completion of academic research projects such as this, I would like to acknowledge a few special individuals. Sue Fisher deserves much credit for this piece of research. She instilled in me the ethnomethodological perspective and in the process taught me not only to see social worlds, but to see how these social worlds are put together by the people living in them.

I would also like to thank my committee members. Tom Hood, as my chairperson, was particularly instrumental in the refinement of this manuscript. Thanks to his insistence on clarity and his belief that if an idea can be expressed in a few words then it should be, this dissertation is much more readable than it might otherwise have been. I would also like to thank Sam Wallace, Suzanne Kurth and Bethany Dumas. Their patience and understanding as committee members, as well as their valuable suggestions, have improved this dissertation considerably.

The data were gathered at a model family practice clinic of a teaching hospital in the southeastern United States. I would like to thank John Eaddy, MD and his staff for their cooperation and interest in this project. Dr. Eaddy was particularly helpful in acclimating me to the research setting and in solving many of the day-to-day problems I faced.

My deepest appreciation goes to Alice. Her unfailing confidence in me and my efforts and her constant support over the years have made the completion of this dissertation a reality.

ABSTRACT

A growing body of sociological literature has examined the ways in which predominantly male doctors communicate with female patients over the course of medical interviews. Research indicates that doctors use the institutional authority of the medical role to control the flow of interaction, the medical interview itself and the delivery of health care to women. Less clear is our understanding of the patterns of communication between doctors and male patients.

Utilizing data gathered in a model family practice clinic of a teaching hospital in the southeastern United States, this study analyzes descriptively the ways in which doctors and male patients interact to produce medical interviews and treatment decisions. Doctor-patient communication is analyzed using discourse analysis to provide a description of: (1) the accounting practices of both doctors and male patients--what kinds of accounts the participants offer each other, how these accounts are offered and responded to and how doctors' and patients' accounting practices affect the structure of medical interviews; and (2) the negotiation of cultural assumptions or norms about how men in our society should behave--how we may locate cultural assumptions in doctor-patient discourse, how cultural assumptions are negotiated between doctors and patients over the course of medical interviews and how these cultural assumptions may affect the delivery of health care to men.

Findings suggest that while doctors employ many of the same manifestations of institutional authority with male patients as with female patients, they do so with less frequency. Doctors reject and fail to respond to male patients' accounts, but since the status of male patients is higher than that of female patients, doctors are more likely to reject and fail to respond to female patients' accounts. A similar pattern is seen in the negotiation of cultural assumptions. Doctors employ assumptions about the behaviors of their male patients and these assumptions have direct consequences for the delivery of health care. Largely because of the status difference between male and female patients, we find that doctors are most likely to negatively categorize female patients.

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CHAPTER I

MEDICAL INTERVIEWS, TREATMENT DECISIONS AND THE SOCIAL CONSTRUCTION OF REALITY: AN INTRODUCTION

A long-standing debate in sociology focuses on the nature of the social world and its relationship to individual behavior. The debate includes positions ranging from the Durkheimian position that an external and constraining reality impinges on both individual consciousness and social action to the position that social actors are not passive recipients of norms but rather are active constructors of social realities. Berger and Luckmann (1967) suggest another possibility. Drawing on phenomenological philosophy they offer a theoretical treatise on what they term a "social construction of reality" position. Berger and Luckmann argue that through the processes of objectivation, institutionalization and legitimation social actors actively produce or construct social realities. Once constructed, these social realities take on the characteristics of an objective, verifiable (external) world.

Berger and Luckmann's "social constructivism" does not suggest that the social world exists merely inside the heads of individuals. As social actors employ interpretive activities they produce meaningful social realities:

While it is possible to say that man has a nature, it is more significant to say that man constructs his own nature, or more simply, that man produces himself . . .

it is important to emphasize that the relationship between man the producer, and the social world, his product, is and remains a dialectical one. That is, man (not of course in isolation but in his collectivities) and his social world interact with each other (Berger and Luckmann, 1967: 49, 61).¹

The authors conclude their work by emphasizing its theoretical nature. They call for "empirical research in the relation of institutions to legitimizing symbolic universes [which] will greatly enhance the sociological understanding of society" (Berger and Luckmann, 1967:188). A number of sociologists have recently undertaken both theoretical and empirical analyses of the social construction of reality: Molotch and Boden (1985) investigated how individuals "talk social structure" during Congressional hearings; Danet (1980) examined how language use affected the social construction of reality during a manslaughter trial; Tuchman (1978) explored local news programs as socially constructed realities; Knorr-Cetina and Cicourel (1981) have begun to link theoretically micro and macro levels of sociological analyses; Cicourel (1983) examined how macro and micro phenomena become linked in individuals' medical belief systems; and Fisher and Groce (1985) and Groce and Fisher (1984) have investigated the reflexive relationship between social interaction and social structure in medical interviews. Despite different terminology, these scholars have all been concerned with the

¹The use of "sic" in this and other quotations has been omitted for ease of reading. It is, however, implied, as I fully realize the problems inherent in the use of male nouns and pronouns to represent both sexes.

relationship between individuals and the social realities which they create or produce.

Research Goal

The goal of this study is to contribute to the growing body of empirical research on the social construction of reality in various social situations. Specifically, the study describes doctors and male patients communicating with each other to produce medical interviews and treatment decisions. The medical setting and the interactions found therein provide an excellent opportunity for us to understand some general processes involved in the social construction of reality. As Navarro (1976) has argued, we may view the medical world as a microcosm of the larger social world. Societal concerns such as social class and stratification, gender and family dynamics are recapitulated in the medical world.

Just as sociologists disagree about the nature of the social world, medical sociologists disagree about the nature of the medical world. Some researchers stress the norms which govern medical relationships, for example, Parsons' (1954) discussion of the sick role. Others, such as Freidson (1970) emphasize how medical behavior is influenced by the organization of the medical profession and specific medical practices (fee-for-service, group practice). Still others focus on how medical realities are accomplished through interaction (e.g., Davis, 1963; Millman, 1976; Roth, 1963).

The study describes how doctors and patients communicate during medical interviews to accomplish ends--the medical treatment decisions

which arise out of doctor-patient interaction. A focus on treatment decisions speaks to a unique reality that doctors and patients work together to construct. Patients seek out doctors to get relief from medical problems. The ways in which two relative strangers come together, establish and maintain a relationship and reach treatment decisions sheds light on the social construction of a specific and a more general reality. Specifically, such an analysis highlights how two individuals, doctor and patient, interact to produce a decision; it simultaneously illuminates how these interactions are produced and constrained by the institutional setting in which they occur.

Preliminary Literature Review

This section provides the reader with an initial review of medical sociological literature pertinent to the study. The scope and focus of the study permit it to touch upon and extend four bodies of literature--work on the structure of medical interviews, the process of doctor-patient communication, the making of medical treatment decisions and institutional authority in the doctor-patient relationship. More detailed literature reviews are found at the beginning of each data chapter (Chapters III and IV).

The Medical Interview

The social construction of reality between doctors and patients in the medical setting relates to work on the structure of medical interviews. We know from the work of Fisher (1984) and Fisher and

sounds like mono
to me

D: has it been going
around that you
know of

P: no oh all I know is
that I felt this
way 20 years and I
was diagnosed as
having mono

D: uh have you had any
sore throat with it

(#45, p. 1)

Medical History Phase

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: okay and you don't have any illnesses that I need to know about not on any medicine at the present	P: not really I've been pretty healthy except for the kidney stones	
D: okay are you allergic to anything except codeine	P: as far as I know I'm not	
D: okay anything else that runs in your family be- sides your father having high blood pressure		

(#35, p. 3)

Physical Examination Phase

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: well let's pull off your shoes	P: well uh you want me	

to take both of
them off

D: yeah

D: let's see this one
here

P: okay

D: where do they burn now P: they just seem like
they burn on the
inner side uh
inside you know

D: in here

P: just uh inside the
toe I know it's//

D: //oh I see what you
mean instead of on
the skin

P: on the skin yeah
just deep inside

(#30, p. 12)

Closing Phase

Initiation

Response

Comment

D: hello well I've looked
at your EKG your heart
exam and your chest x-
ray I really don't see
any significant prob-
lems with either one
of those uh I have got
some blood work you
know that has not come
back yet but it should
be back in a few days
uh then I'll let you
know about that if
there's any abnormal-
ity uh here is some
medication for uh the
uh I think a lot of
this may be muscle
problems and uh I do
think some of this
and I'm not saying
all of it is related
maybe to some anxiety
stress that you've
been under you've

We know that the phases of the medical interview have their own typical structure. For instance, in the opening phase the patient usually does most of the talking while describing the presenting complaint. In the medical history and physical examination phases the doctor controls the floor by asking many short information-gathering questions. In the closing phase the doctor typically initiates most of the conversation in describing the treatment decision. We also know that sociological considerations such as doctors' institutional authority, patients' social statuses and communicative styles may affect the structure of medical interviews (Hughes, 1982; Waitzkin, 1985; Fisher and Groce, 1985). Most of the research on the structure of medical interviews has been conducted using samples of female patients (Fisher and Groce, 1985) or samples of male and female patients together (so that medical interviews with male and female patients have never been compared) (Hughes, 1982). We have no information on what the structure of

been under so much stress// lately that I'd like to give you some medication	P: //uhm
	P: okay
D: you take one of these every 4 to 6 hours	P: 4 to 6 hours D: uhuh
P: will it have any effect on me can I take it at work or at nights	D: no uh you can take it uh like I told you you have a heart murmer

(#27, p. 15)

medical interviews with male patients looks like, whether it is similar to or different from the structure of medical interviews with female patients.

Medical Treatment Decisions

This research also contributes to the medical sociological literature on how doctors reach treatment decisions during medical consultations. In recent years medical decision-making (also termed clinical reasoning and medical problem-solving) has increasingly become a focus of attention for researchers (Cutler, 1979; Wortman et al., 1972; Vu, 1979). Current work concentrates on problems related to the process of medical decision-making and its outcomes in clinical encounters between doctors and patients. Some researchers have examined the relationship between well-developed problem-solving, decision-making skills and effective clinical practice (e.g., Voytovich and Rippey, 1982). Others such as Spiegel et al. (1982) and Miller and Schaffner (1982) have investigated ways of improving the teaching of decision-making skills to medical students. Still others have sought to explicate the ways in which doctors actually make medical decisions, suggesting computer, Bayesian, logical and information-processing models (Felstein, 1967; Schwartz et al., 1973; Pauker and Kassirer, 1975; Warner et al., 1961; Jacquez, 1964; Elstein et al., 1978).

Most of the work on medical decision-making has virtually omitted any sociological considerations which might be involved in the process through which doctors and patients arrive at treatment decisions.

Work on medical decision-making typically operates at an analytic level, thus failing to address what actually goes on in the examining room between the two principal interactants (e.g., Elstein et al., 1978). Such an omission is noteworthy, for as Henderson (1935) noted early on, medical reasoning and decision-making are most profitably understood as social interactional events. Given the asymmetry of the doctor-patient relationship (Parsons, 1954) and the institutional authority of the doctor (Freidson, 1970), some important correlates of social stratification--the race, gender and socioeconomic statuses of both doctors and patients--are critical to an understanding of the social construction of medical treatment decisions. As Eisenberg (1979:957) has observed, "Actual clinical decisions . . . are influenced by interactions between the clinician, the patient, and the sociocultural milieu, as well as by biomedical considerations."

Communication in Medical Interviews

This research focuses on how residents in a model family practice clinic and adult male patients communicate to accomplish medical interviews and treatment decisions. The focus on male patients is particularly important because my literature reviews have revealed no studies which examine communication between doctors and male patients. Many studies of medical communication employ mixed samples of patients--male and female patients are not separated and compared in the analyses (e.g., Pentell et al., 1982; Comstock et al., 1982;

Pfefferbaum et al., 1982; Coulthard and Ashby, 1975; Hughes, 1982; West, 1983; Smith et al., 1981).

An increasing number of studies focus exclusively on female patients (e.g., Bonanno, 1982; Shapiro et al., 1983; Waitzkin and Stoeckle, 1976). Waitzkin and Stoeckle (1976) and Shapiro et al. (1983) have shown that doctors exercise information control when interacting with female patients. Doctors frequently do not give women the full information necessary for them to reach informed decisions about treatment options, apparently assuming that they are incapable of understanding complex medical discussions. These and other studies also indicate that while female patients receive less information than they might otherwise need, they actively seek more information during medical consultations.

Fisher's work (1979, 1980, 1982, 1983) on institutional authority and the structure of discourse, Fisher and Groce's (1985) study on the negotiation of cultural assumptions and the delivery of health care and Groce and Fisher's (1984) research on the structure and function of patients' accounts also rely solely on samples of female patients. From these studies we know that: (1) women give a variety of accounts for their behavior during medical interviews, employing justifications and excuses with almost equal frequency; (2) doctors either openly reject or fail to respond to female patients' accounts four times as often as they accept them; (3) doctors form evaluative perceptions of their patients as either "good" or "bad" women over the course of medical interviews; and (4) these evaluative perceptions,

once formed, appear to influence the delivery of health care to female patients. Doctors tend to give more and more thorough medical attention to female patients they have evaluated positively and less to those they have evaluated negatively.

The studies which employ mixed samples of male and female patients give no consideration to how the status of male or female patients may affect the social construction of medical realities. The studies which focus solely on interactions between doctors and female patients acknowledge that the status of female patient is an important variable, but they do so without comparable data on male patients. Only a handful of published studies demonstrate that other variables change when male and female patients interact with doctors (Schiefelbein, 1980), but none focus on the process of communication between doctors and patients and the realities they create. Najman et al. (1982) have found that doctors use one set of stereotypes for male patients and a different set for female patients. Armitage et al. (1979) demonstrated that doctors rendered more extensive diagnoses to male patients than to female patients. Colemeco et al. (1983) found that doctors attribute more emotionality to women than to men and tend to evaluate women's complaints as less serious than men's complaints. Finally, in an unpublished study, West and Guiffre (1980) have demonstrated a tendency for doctors to interrupt female patients considerably more often than male patients.

The Role of Institutional Authority

Conversation analysts have demonstrated repeatedly that everyday talk displays a balanced structure. People make statements and comments, ask each other questions and give each other replies based on the phenomenon of turn-taking. That is, everyday conversation is usually a matter of equal participation by the interactants. Zimmerman and West (1975) have shown that variables such as status and power frequently disrupt equal participation in conversation, particularly in terms of gender. Men interrupt women and fail to answer women's questions much more often than is the case when men talk with men or women talk with women.

The influence of power and status on talk becomes even more important in institutional settings. Institutional contexts are organized to give certain social actors the power and control necessary to achieve the goals of the institution. Thus, in classrooms teachers have institutional authority (Mehan, 1979), while in courtrooms lawyers and judges are empowered with authority and control (Cain, 1983). Institutional authority necessarily means that people interacting within institutional contexts are set in asymmetrical relationships with each other.

The medical setting is institutional. We find that doctors have institutional authority which patients lack, thus making the doctor-patient relationship asymmetrical (e.g., Fisher and Groce, 1985, 1986; Ehrenrich and Ehrenrich, 1978; Zola, 1978). When doctors are men and patients are women, doctors control interaction during

medical encounters. The asymmetry of the doctor-patient relationship is manifested in the discourse produced during medical interviews. Doctors interrupt female patients, do not answer all their questions; they generally control the flow of interaction with female patients.³ However, we have no information on doctors' use of institutional authority with male patients. It is not clear how a patient's gender actually affects the doctor-patient relationship, if doctors communicate differently with men than with women as they socially construct treatment decisions.

Outline of the Study

Chapter II provides the methodological framework for the study. In it I discuss the research setting, patient and doctor population, sampling technique and method of analysis. Chapters III and IV are the substantive analysis of the doctor-patient interviews. The focus of Chapter III is the phenomenon of accounts--how doctors and patients account to one another for non-normative behavior during medical interviews and how the process of accounting influences the structure of these interviews. Chapter IV examines one of the influences on the social construction of medical treatment decisions--

³This is not to say that doctors always possess power and patients always lack it or, for that matter, that in any institutional context the dominant actor(s) always maintains control. It is only to say that the normative structure surrounding interaction in institutional contexts and the shared expectations of institutional authority give rise to certain linguistic behavioral patterns.

how the evaluative perceptions doctors form about their patients influence the type of medical care they give. Following a short chapter devoted to summary and conclusions is an extensive theoretical appendix which addresses the linking of macro and micro levels of analysis in the social construction of reality. In addition to suggesting how we might construct a language-based theoretical model for integrating macro and micro, this section also emphasizes how such a model might be applied fruitfully to the study of doctor-patient communication.

CHAPTER II

THE METHOD OF INQUIRY: A DISCOURSE ANALYSIS OF MEDICAL INTERVIEWS

. . . there is no societal reality, with all its concrete forms, that does not bring itself to representation in a consciousness that is linguistically articulated. Reality does not happen "behind the back" of language; it happens rather behind the backs of those who live in the subjective opinion that they have understood "the world"; that is, reality happens within language.

--Hans-Georg Gadamer, Philosophical Hermeneutics

The Research Setting

The setting for this research was a model family practice clinic of a teaching hospital located in the southeastern region of the United States. The hospital's patient population is somewhat polarized. Patients tend to be from either the upper or lower socio-economic levels, with few patients representing the middle levels. Since the hospital is part of a state university system, residents at the family practice clinic treat many university professors and administrators (who receive special discounts). Since the clinic is a teaching facility, residents also see many welfare recipients, underemployed and unemployed patients who visit the clinic because prices are lower than in private practice. Approximately 15 percent of the clinic's patients are black (see Appendix IV).

The residents at the clinic were generally an energetic, enthusiastic group. Although they were somewhat hesitant and reserved

around me at first, we had little difficulty establishing good rapport. After I gained their confidence we talked freely about many and varied topics. Some discussions emphasized our similarities as students attempting to complete rigorous programs. Others focused on aspects of the clinic and patients' care. Overall, my reactions to the residents were positive--in most cases they seemed genuinely concerned with providing quality care to their patients. An unavoidable influence on any researcher's observations is his evaluation of and reaction to who/what he observes. Throughout this project I tried to minimize the biases which result from preconceived attitudes by continually reviewing my conclusions and generalizations and striving for accuracy.

As a resident training facility, this clinic is organized much like a group practice. Patients telephone ahead for appointments; if they do not request a specific physician, they are assigned one based on availability. When patients arrive, they sign in at the front desk and take a seat in a large waiting area which is furnished with sofas, chairs, tables (with a variety of popular and health/medical publications) and a color television set. About fifteen minutes before a new patient is scheduled to see a doctor, he is called into a small interview room to the side of the waiting area. "New records" personnel interview new patients in order to construct medical records files. They record patients' basic demographic information as well as brief medical and social histories.

A few minutes before the doctor is ready to see a patient, his nurse calls the patient back to a small waiting room which is down the hall from the larger waiting area. This room contains four chairs and a small table in addition to a large desk which serves as the nurses' station. It also contains the equipment with which nurses measure patients' height, weight and blood pressure. After a nurse measures and records the patient's height and weight, the patient then sits in the sub-waiting area until an examining room becomes available. When a room is ready, the nurse escorts the patient into it and measures and records the patient's blood pressure. The nurse leaves the patient sitting in the examining room and affixes the patient's chart to the outside of the door through which the doctor will eventually enter. Before the doctor enters the examining room, he always briefly reviews the patient's chart (which includes the demographic and health information recorded earlier) and sometimes consults with the attending nurse.

The examining rooms are relatively small, about twelve feet by ten feet (with nine foot ceilings). A metal examining table sits in the middle of each room. One small chair rests in the corner of each room directly across from the main entrance. These chairs are used either by doctors or by friends/relatives of the patients. Each examining room has two doors, one of which opens to the outside corridor (for patients' access) and one which opens inside to a large conference room (for doctors' and nurses' access). This conference room is furnished with two large tables, fifteen to twenty

chairs, an overhead projector (for lectures and seminars) and two dictating machines (used by doctors to record observations, assessments and diagnoses which eventually end up in patients' files). When doctors are not busy examining patients or when doctors require consultation with attending staff physicians and/or nurses, they use this conference room. The conference room is also used for lectures, films or discussions which are routine parts of the residents' training program. There is another, smaller conference room, located between the outside waiting area and the examining rooms, which functions as a lounge for doctors and nurses. Immediately behind the receptionists' station, just off the outside waiting area, is the records room. This small, square room contains six large shelves which house the color-coded manila folders where patients' medical records are kept. All staff and support personnel have access to the files in this room. This includes staff physicians, residents, nurses, the clinical psychologist, the nutritionist, the social worker and the records personnel.

Data Sources

I relied on a number of data sources in descriptively analyzing the process through which doctors and male patients interact to socially construct medical interviews and treatment decisions. The major data source used in this research was the actual discourse produced by family practice residents and new male patients during medical interviews. I used forty-three male first-time users of

the Family Medicine Outpatient Clinic between June 1, 1983 and June 1, 1984 who agreed to participate in the study by signing an informed consent form.¹ I also used the fifteen second- and third-year male residents at the clinic. I based sampling decisions strictly on practical considerations, most notably my schedule for availability at the clinic and the availability of the two examining rooms equipped with cameras and microphones, as well as both patients' and residents' consent to participate. The only patient selection criteria were that the patients were men who were at the clinic for initial visits and who were scheduled to be examined in rooms with cameras. There were no criteria of age, place of residence, method of payment, etc. Residents did not have a role in the patient selection process.

Another data source was each consenting male patient's medical records file. I used patients' medical records to provide access

¹The forty-three men who agreed to participate in the study represent 87.8 percent of the total number of men I asked to participate (N=49). Those who were initially approached but were not included in the study were: (1) a young man who had just reached legal age (eighteen). His presenting complaint concerned something about his penis and sexual dysfunctioning. His parents had accompanied him to the clinic. While he initially agreed to participate, his mother raised such strong objections that he changed his mind and withdrew consent; (2) a middle-aged man who was so obviously under the influence of alcohol or some other drug that he was almost incoherent. In this instance, I decided he should not be included in the study; (3) a patient from a local mental institution. Again, since "competence" was at issue, he was not included; (4) a deaf patient. While I was interested in the uniqueness of this situation, I was forced to exclude him because of the problems inherent in the presence of a third party--his sign interpreter; and (5) two men in their late twenties or early thirties, professional in appearance and demeanor, who stated simply that they chose not to participate.

to demographic and background information as well as to follow the evaluation of each patient, his medical problem and the medical treatment decision. Patients' files typically included information on age, marital status, occupation, education and income. They also usually contained a section on life-style information which briefly described eating habits, tobacco and alcohol use and leisure-time activities. Residents were required to submit a review of each medical interview and an evaluation (treatment decision) to the files. Residents dictated their remarks (a legal safeguard) and secretaries placed transcripts of these remarks in patients' files.

I used additional ethnographic materials to supplement/augment my analysis of doctor-patient communication. I relied on impressionistic observations during my time at the clinic as well as on field notes. There were many instances where this technique proved valuable. Either between scheduled taping sessions or in the absence of scheduled subjects, I had many opportunities to talk "informally" with doctors, nurses and support personnel on topics ranging from the organization of the clinic to the types of patients doctors like and dislike.

A final data source was residents' reactions to evaluations of the previously taped interviews. I used fifteen audio-taped medical interview review sessions. The number of taped review sessions was chosen out of practicality. Given the hospital's organizational constraints in terms of time, facilities and case load, fifteen was the maximum number of review sessions that could

be taped. The audio-tapes of these review sessions served as the basis for the expansion technique discussed earlier.²

Data Collection

The major method of data collection in this research was the audio- and video-taping of initial medical interviews between residents and new male patients. Following Fisher (1983), Cicourel (1983), West (1983) and Mehan (1979, 1983), I argue that the best way to examine how social actors actively produce social realities is through a detailed study of the communication between them. So, in order to examine how doctors and patients socially constructed medical interviews and treatment decisions, it was necessary to have access to their linguistic productions. While it might have been possible to produce a reasonable account of doctors' and patients' talk through some type of observational coding scheme, it seemed more advantageous to be able to reproduce the actual discourse in its entirety. I decided to employ taping procedures because both audio- and video-tapes can freeze segments of interaction. This allowed me to review continually the same interaction, to probe the material for patterns that may have escaped notice earlier.

²As is often the case, the parameters of this study changed during the data analysis stage. This meant that I could not utilize the expansion technique as fully as I had originally expected. The review sessions with residents were conducted before I noticed the patterns of accounts and cultural assumptions in the data. Therefore, I missed a good opportunity to ask residents specifically about these phenomena.

Critics have often objected to the taping of social interaction. They argue that recording equipment is obtrusive and, therefore, contaminates (changes) the interactional situation. While the presence of recording equipment in the examining room may cause doctors and patients some uneasiness during the first few minutes of the medical interview, I agree with Kendon (1979:19-20) that there is good reason to assume that individuals' awareness of recording equipment rapidly fades into the background and becomes a taken-for-granted feature of the setting. The taken-for-granted nature of the taping is heightened by the fact that the residents were accustomed to being audio- and video-taped. As part of their training programs they were routinely taped and their examining room performances were routinely reviewed and evaluated by staff physicians, the clinical psychologist and the social worker at the clinic.

My observations and field notes were also data collection strategies. I recorded relevant information from observations as it occurred by removing myself from conspicuous locations and away from clinic personnel. I also constructed field notes by systematically reviewing each day's occurrences after I left the clinic.

Limits of the Study

I have observed a number of limits which served to make this a manageable research project. The first concerns the research setting and its interactants. While the optimum strategy would

obviously have been to investigate the social construction of medical interviews and treatment decisions between male and female doctors and male and female patients in a number of different settings (e.g., private hospital, private practice, group practice, etc.), my research was limited to focus on interactions between male doctors and male patients in a family practice clinic of a major university teaching hospital. These limitations were more practical than theoretical. Most doctors in the United States are male and the residents in this study were no exception. As discussed earlier, there is some research on female patients but none on male patients. Finally, access to a medical setting is difficult to achieve. My access to the family practice clinic where the research was conducted was facilitated by another member of the academic community who had done prior research in this setting.

The setting itself placed further limits on my research. First-year residents in this clinic have very limited clinical exposure. Therefore, my research was limited to second- and third-year residents who provided a stable and more similar physician population. The major differences in residents' behaviors occur between first- and second-year residents and the advanced residents are more similar to established doctors than first-year residents (Brown and O'Shea, 1980; Helfer et al., 1975).

An additional limitation was the focus on patients' initial visits to the clinic. I based this decision on the assumption that doctors and patients who have seen each other previously will have

developed interactional styles for communicating with each other. I recognized that it was impossible to obtain "pure" interaction uncontaminated by the prior experiences of both doctors and patients. Both interactants are members of the same society. Thus, the statuses of "doctor" and "patient" and the roles surrounding them are infused with preexisting, culturally created meanings. I did, however, wish to capture doctor-patient interactions at their beginning so I could investigate how these culturally produced meanings got worked out during the interactions and how these meanings influenced the social construction of medical interviews and treatment decisions.

Other limits to the study were based on practical considerations. My sample consisted of forty-three initial medical interviews. The sample size resulted from the financial constraints associated with the cost of video-tapes. The family practice clinic agreed to provide me with twelve sixty-minute video-tapes. Given that each initial medical interview lasted just under fifteen minutes, I was able to record four or five interviews on each tape--hence, the total of forty-three recorded interviews. The study was further limited by the fact that the sample could not be randomly drawn. The family practice clinic had twelve examining rooms, only two of which were equipped with cameras and microphones. Since new male patients were assigned to the video examining rooms as they arrived at the clinic, I missed a number of patients because the video-taping rooms were already occupied. Sample randomness was also impossible to achieve because of time constraints. Given my

own teaching schedule, I could be at the clinic only on weekday afternoons.

My analysis of how doctors and men patients communicate to produce medical interviews and treatment decisions was also limited. One could easily argue that the nonverbal gestures and cues which accompany medical discourse are an integral part of the social construction of medical events. To speak of verbal interaction and nonverbal interaction is actually an arbitrary and somewhat misleading distinction. Social scientists are usually forced to make this distinction purely out of practicality--to undertake simultaneous analysis of both dimensions of social interaction quickly becomes an unmanageable task. The present research is no exception. The task is to focus primarily on the linguistic productions of doctors and patients during medical interviews.³

One could easily argue that the number of variables affecting doctor-patient interaction and the negotiation of treatment decisions is virtually limitless. To attempt to address many issues simultaneously would have rapidly become an unmanageable task. If we envision the social construction of medical interviews and outcomes as a giant puzzle, each variable or issue becomes a piece of that puzzle. For example, some of the relevant puzzle pieces might be

³An unfortunate weakness of the study developed when the hospital requested that I return their videotapes. In our original agreement I was to keep the tapes for two years following completion of the project. However, due to circumstances beyond my control, hospital administrators recalled the tapes before I had finished with them. They stated that they required them for teaching purposes.

the race and ethnicity of both doctors and patients, doctors' and patients' gender, patients' social class position, the institutional authority of doctors, the social organization of the medical setting and the socioeconomic structure of society. Perhaps the study's most important limitation is its inability to isolate the simultaneous effects of many of these considerations. The major goal of the study is to analyze descriptively how doctors and male patients socially construct medical interviews and treatment decisions. Due to sample size and other considerations we are not in a position to isolate the effects of patients' race, age, occupation, social class position, etc. We can, however, make some initial observations concerning what happens in medical interactions when the relative status difference between doctors and their patients changes. By comparing some of my results with results from studies on interactions between doctors and female patients we may identify interactional patterns peculiar to medical interviews where the relative status difference between doctors and patients is large (as in the case of female patients) and where the relative status difference is smaller (male patients).

As I reviewed the transcripts of the interviews over and over again, I was struck by two patterns. The first was how doctors and male patients accounted to each other for atypical or deviant behaviors and the types of responses these accounts generated. The giving of and responding to accounts influenced the social construction of reality most noticeably by influencing the structure

of the medical interviews. The second pattern was how doctors displayed cultural assumptions (positive and negative) about what kinds of men their patients were. These cultural assumptions influenced the social construction of reality by affecting ultimately the medical treatment decisions that doctors made for their patients. These two patterns became the substantive or data chapters for the research project. They represent two pieces of the puzzle of the social construction of reality of medical interviews and outcomes. Their analysis reveals some of the work that both doctors and patients engage in as they interact with each other.

Commonly-used Research Strategies

A variety of research strategies and analytic frameworks exist for the investigation of doctor-patient communication. I will briefly review and critique the predominant strategies, commenting on their utility in allowing us to analyze how, through language, doctors and patients socially construct the reality of medical interviews. The most frequently employed categorization system for encounter events is the Bales Interaction Process Analysis (Inui et al., 1982). Originally developed for the study of small group interactions, the Bales system is based on the ability of observers to code interactional events into twelve mutually exclusive categories. In this scheme, interactants may: (1) show solidarity (raise the other interactant's status, give help or reward; (2) show some tension release (joke, laugh, show satisfaction); (3) agree (show passive

acceptance, understand, concur, comply); (4) give suggestions (directions, imply autonomy for others); (5) give opinions (evaluation, analysis, express feelings, wishes); (6) give orientation (information, repeat, clarify, confirm); (7) ask for orientation (information, repetition, confirmation); (8) ask for opinions (evaluation, analysis, expression of feelings); (9) ask for suggestions (direction, possible ways of action); (10) disagree (show passive rejection, formality, withhold help); (11) show tension (withdraw asking for help); and (12) show antagonism (deflate other's status, defend or assert self) (Bales, 1950).

While the Bales system continues to be widely used in the analysis of doctor-patient communication (e.g., Freemon et al., 1971; Davis, 1968; Smith et al., 1981; Korsch and Negrette, 1972; Korsch et al., 1968; Korsch and Morris, 1969) and in some instances has been greatly revised (e.g., Pantell et al., 1982), it has met with serious criticism. Inui et al. (1982) argue that the Bales system is too time consuming, while Carter et al. (1982) document problems with observers' coding accuracy. More importantly, the Bales system makes data, once coded, irretrievable:

The rich formal texture of conversation is abridged and encapsulated by this device, but there is no possibility of recovering the further structure once such categories are taken as the primitive elements (Labov and Fanshel, 1977:17).

Finally, Mehan (1979:10) has observed why the Bales system is severely limited in its usefulness for studies of the on-going construction

of social realities: "The fundamental consequence is that the contingent nature of the interaction is obscured" [my emphasis].

By "contingent nature" Mehan refers to the negotiations between interactants, the relationship between verbal and nonverbal behavior, the relationship between talk and context and the multiple functions of language. In other words, the intricacies of social interaction are too subtle and too complex to be neatly handled by Bales's quantitative coding strategy.

The Verbal Response Mode (VRM), developed by Stiles (1978) and Stiles et al. (1979), has also been employed in the analysis of doctor-patient communication. Researchers using the VRM analyze transcripts of the actual dialogue produced in medical interviews by employing language structure as a marker for interpersonal intent between communicator and recipient. Researchers classify each verbal unit according to its grammatical form (based on sentence structure) and intent. Intent includes focus--other or speaker, source of experience or information (topic--speaker or other) and frame of reference--whose point of view an utterance is to be understood from (speaker or other). The following is a representation of the VRM:

FOCUS OF UTTERANCE	SOURCE OF INFORMATION	FRAME	
		SPEAKER	OTHER
speaker	speaker	disclosure	edification
	other	question	acknowledgment
other	speaker	advisement	confirmation
	other	interpretation	reflection

Like the Bales system, the most serious drawback to the Verbal Response Mode is its inability to allow researchers to analyze the negotiated and contingent qualities of interactions between doctors and patients.

Another analytic framework employed in the study of doctor-patient communication is Roter's (1977) Interaction Analysis (IA). The IA focuses on the identification and clarification of verbal events. Researchers carry out the analysis from audio-tapes, thus bypassing the transcription stage. The Roter system also allows for the categorization of tonal qualities during verbal interaction. The following is a representation of the Roter system:

PHYSICIAN	PATIENT
(1) personal remarks	(1) same
(2) shows approval, gives compliment	(2) same
(3) statement, gives information, opinion	(3) same
(4) gives direction, instruction	(4) request for medication
(5) asks questions	(5) bid for clarification
(6) direct request for questions	(6) asks questions
(7) shows agreement and/or understanding	(7) same
(8) shows disagreement and/or criticism	(8) same

While Carter et al. (1982) have judged the Roter method useful in predicting patients' compliance with medical regimens, they find it lacking in its ability to predict other variables such as patients' satisfaction with medical encounters and treatment decisions. Based on the previously discussed critical remarks by Labov and Fanshel

(1977) and Mehan (1979) concerning any exclusively quantitative coding approach, I would also add that the Roter method is of questionable utility in the analysis of how doctors and patients socially construct medical interviews.

A final categorization system for the analysis of doctor-patient communication has been developed by Skopek (1979). In recognizing that linguistic structures appear to reflect the ways in which speakers organize the meanings of experienced events, Skopek has suggested a model which employs Main Conversational Divisions of MCD's as the units of analysis. Her MCD's are as follows: (1) opening/closing--the social ritual of greeting and leave-taking; (2) narrative--a sequence of utterances by the speaker usually reporting symptoms, facts or events; (3) explanation--a sequence of utterances by one speaker to ensure that another understands; (4) interrogation--a series of questions on various subjects; (5) elicitation--a series of short questions zeroing in on a specific topic which is usually established by interrogation; (6) bantering--casual joking between doctor and patient on subjects unrelated to the medical interview; (7) idling--casual conversation on unrelated subjects; and (8) discussing--a sequence of utterances involving both doctor and patient which lacks unity of content. One major problem with Skopek's MCD model is the establishing of intent--which type of MCD did a speaker intend an utterance to be. A second problem is that the MCD model obscures the function of talk between doctor and patient. There

is no way to retrieve how communication influences the social construction of the medical event.⁴

I have argued, following Labov and Fanshel (1977) and Mehan (1979) that quantitative coding systems such as those developed by Bales, Roter, Stiles and the like, are lacking on at least two counts. First, any system wherein a researcher simply formulates an analysis based on the counting of certain types of utterances distances him/her from the context in which doctors and patients produced those utterances; once the context is lost, it is irretrievable. Second, any quantitative coding system obscures what interactants do with what they say--the functions of language during social interaction; thus, inferences about how language influences the social construction of medical events become impossible.

One way around the problems inherent in quantitative coding schemes is for researchers to employ variations of "microanalysis" (Labov and Fanshel, 1977:19-23) or "constitutive ethnography" (Mehan,

⁴There is also an electronic system for the analysis of communication called the Computer Assisted Language Analysis System (CALAS). CALAS utilizes a three step process in its case grammar analysis of texts. CALAS has been fruitfully employed in the analysis of therapeutic counseling sessions to document the "tracking" phenomenon (where a client's speech style approximates that of the counselor) (Mears et al., n.d.). It has also been used to analyze classroom interaction (Pepinsky and De Stefano, 1980; Pepinsky et al., n.d.). CALAS's heavy reliance on structure produces a richly detailed description of the words people use when they interact with each other. It cannot, however, address the issues of process in social interaction--what gets done with what social actors say to each other; therefore, it was of little utility in exploring how doctors and patients communicate to interactionally produce medical interviews and outcomes.

1979:16-24) in the analysis of doctor-patient communication. Such research strategies focus simultaneously on both the structure and function of the language social actors produce during actual interactional events (e.g., medical interviews). Microanalysis or constitutive ethnography improves on quantitative coding systems in four ways. First, the data are retrievable. Unlike quantitative strategies in which data are coded into researchers' abstracted categories, qualitative constitutive ethnographies typically record interactions on audio- and/or video-tape. Thus, the data are always available for alternative interpretations (Cicourel, 1968:2). Second, researchers using a constitutive ethnographic approach seek to provide comprehensive data treatment. In quantitative schemes, data are often selectively analyzed in an effort to confirm or reject certain hypotheses (Mehan, 1979:20); in constitutive ethnographies, researchers begin with the data themselves (in this case, the interviews between doctors and male patients) and search for patterns which suggest various interpretations. Thus, this type of research is "data driven" (Cicourel, 1980b). Third, the constitutive ethnographic approach seeks to avoid the abstracted descriptions and explanations which characterize quantitative coding schemes (Mehan, 1979:22). The explanations and descriptions of events by constitutive ethnographers must be similar to participants' explanations and descriptions of the same events (Garfinkel and Sacks, 1970:345). Fourth, researchers using constitutive ethnographies ground their analyses in the actual interactions of the participants under study. As Sacks (1963:3)

has emphasized: "If it is a phenomenon, it must be in the interaction."

The most profitable method with which to analyze doctor-patient communication seems to be a constitutive ethnography of some variety, one that allows the researcher to emphasize "the study of discourse and the larger context of social interaction [through] explicit reference to a broader organizational setting and other aspects of culture" (Cicourel, 1980a:2). In the following section, I will discuss one such constitutive ethnography, discourse analysis, as the best method to employ in my analysis of how doctors and patients interact to socially construct medical interviews and treatment decisions.

Discourse Analysis

For the purpose of sociology, discourse analysis has been defined as the study of the exchange of speech acts as they occur in social interactional contexts (Cicourel, 1980b:101) or the study of how things "get done" with what "gets said" (Grimshaw, 1981, 1982).⁵ Researchers who employ discourse analysis emphasize a number of features which distinguish it from other analytic techniques: (1) the importance of studying naturally occurring discourse; (2) the

⁵Grimshaw cites his indebtedness to the earlier work of Austin (1966) and Searle (1969) in speech act theory. See Pecheux and Fuchs (1982) for a discussion of the evolution and development of the term "discourse analysis" within linguistics and other disciplines.

importance of continually making reference to the social contexts in which interactants produce discourse; (3) the importance of using multiple sources of data--including but not limited to verbal and nonverbal cues, ethnographic information and observation (see Corsaro, 1981, for a full discussion of the scope of discourse analysis). Discourse analysis is not, however, unidimensional; it encompasses at least five analytic approaches, each of which has a slightly different scope and focus. In the following paragraphs I will review the two varieties of discourse analysis which, when combined, have (in my estimation) the most utility for my analysis of how doctors and patients communicate to socially construct medical interviews.⁶

One major approach to discourse analysis may be termed the "interactional accomplishment" model. The interactional accomplishment model was originally developed by Mehan (1979) for the analysis of classroom interactions between teachers and students. Mehan's discourse analysis model derives from Garfinkel's (1967) insistence that social reality is a practical interactional activity. Thus,

⁶Space does not permit a detailed treatment of all the varieties of discourse analysis. Not treated in this manuscript are: (1) the early work of Harvey Sacks (1972, 1973, 1978) which focuses on the maxims of practical reasoning and social cognition; (2) the majority of work by other conversation analysts (e.g., Jefferson, 1972, 1975; Sacks, Schegloff and Jefferson, 1974; Schedloff and Sacks, 1974; Schedloff, 1972; Schenkin, 1978) whose focus was on the sequential structuring of ordinary conversation through the use of adjacency pairs; and (3) the later work of Erving Goffman (1974, 1981) who emphasized how actors' presentations of selves influences discourse events (see Corsaro, 1981; Cicourel, 1980b; and Grimshaw, 1981 for extended discussions of the varieties of discourse analysis).

Mehan analyzed student-teacher discourse in an effort to demonstrate how classroom lessons are the joint interactional accomplishments of both teachers and students.

The use of the interactional accomplishment model enabled Mehan to identify the basic structure of classroom interaction, the "three-part interactional sequence." The following examples illustrate the characteristic form of the three-part sequence (Mehan, 1979:52).

<u>Initiation</u>	<u>Reply</u>	<u>Evaluation</u>
T: and whose is this	Many: Veronica	T: oh a lot of people knew that one
	And:	
T: uhm whose name is this	L: Mercedes	T: Mercedes all right

These bits of discourse are produced in "co-occurrence relationships," wherein

the appearance of one form of informal speech (such as an address term) will be followed by the appearance of other informal ways of talking. The conversational forms that are related to each other by these co-occurrence rules often appear side by side (Mehan, 1979:50).⁷

The first part, the initiation, is typically (though not always)

⁷Co-occurrence members typically occur in conversation as adjacency pairs. Adjacency pairs may be defined as "conversational forms that are related to one another, and usually occur side by side. These forms are structured by a reciprocal relationship which converts separate speech acts into unfolding social acts requiring cooperative participation. Given the first pair-part of an adjacency sequence, the second pair-part is conditionally relevant--the first statement provides the possibility for the second and the second gives meaning to the first" (Fisher, forthcoming:14).

made by the interactant with the highest status (the one who controls the interaction--in this case, the teacher). The second part is the reply which makes sense out of the first part ("Whose name is this?"--"Mercedes"). The third part is an evaluation of the second part ("Mercedes, all right"). Taken together, these three parts provide the structure upon which teachers and students generate classroom lessons.

Mehan's use of the interactional accomplishment discourse analysis model also enabled him to identify the sequential organization of classroom lessons. Each lesson is comprised of an opening phase, an instructional phase and a closing phase. During the opening phase teacher and student communicate the information that what is about to occur will constitute a lesson (as opposed to some other activity). The heart of the lesson is the instructional phase. It is during this phase that teacher and students exchange academic information. In the closing phase, both parties summarize what has just taken place and prepare to move on to some other activity. The examination of the discourse produced by teacher and students enabled Mehan to document the interactional work required in the social construction of classroom lessons.

The interactional accomplishment model of discourse analysis has recently been applied to the study of doctor-patient communication (e.g., Fisher, 1979, 1980, 1982, 1983, forthcoming; Fisher and Groce, 1985; Groce and Fisher, 1984). Researchers have found that doctor-patient discourse displays a three-part sequence similar to that discussed by Mehan:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: what brings you in today	P: well I've had this backache	D: backache
D: how long has it been bothering you	P: oh I guess about two weeks	D: uhuh

Notice that the organization of communication in the medical setting differs from the organization of communication in the educational setting. In the classroom, the third part of the sequence is the teacher's evaluation (either positive or negative) of the previous reply. In the present example, it makes no sense to talk about a doctor's evaluation of a patient's response. The doctor does not say, "Yes, backache is the correct response," or "No, you should not have said 'backache.'" Rather, the doctor's third part becomes a comment, typically a "backchannel" cue (Duncan, 1972) which signals the patient that: (1) the doctor is paying attention; and (2) what the patient is saying is understandable.

The value of the interactional accomplishment model of discourse analysis lies in its ability to allow the researcher to remain close to the data. That is, the researcher relies on the discourse itself to display interactional patterns, thus avoiding the previously discussed problem with quantitative coding schemes, i.e., abstraction to the level of sociologists' (as opposed to members' or participants') categories. The researcher is in a better position to contextualize what interactants say and to document how the discourse contributes to the social construction of reality.

The second model of discourse analysis relevant to my research was developed by Labov and Fanshel (1977). Their technique, comprehensive discourse analysis, has been called "the most extensive substantive application of any discourse model yet to appear in the literature" (Corsaro, 1981:42).⁸ The objective of comprehensive discourse analysis is to identify "the interactional accomplishment 'intended' by interlocutors in ongoing conversational discourse" (Grimshaw, 1981:225). Labov and Fanshel's discourse analysis builds on the earlier work of Labov (1970, 1972a, 1972b) which focuses on generative semantics, speech act theory and nonverbal communication.⁹ Their model was also greatly influenced by Pittenger et al.'s The First Five Minutes (1960). This publication marked the shift to the detailed analysis of verbal behavior through the use of tape-recorded materials. From The First Five Minutes Labov and Fanshel derived nine fundamental principles which guide their model of discourse analysis:

- (1) Immanent Reference--no matter what else human beings may be communicating about . . . they are always communicating about themselves, about one another, and about the immediate context of communication.

⁸See Grimshaw (1979), Cicourel (1979) and Russell (1979) for other thorough reviews of the Labov and Fanshel model.

⁹Labov and Fanshel's approach to discourse analysis is somewhat similar to Cicourel's (1980b) cognitive discourse analysis model. A cognitive orientation emphasizes the interconnectedness of linguistic, cognitive, and cultural variables in the study of discourse.

- (2) Determinism--any communicative act is, indeed, culturally determined: the indeterminant is . . . non-existent.
- (3) Recurrence--anyone will tell us, over and over again . . . what sort of person he is . . . what his likes and dislikes are, and so on . . . crucial patterns of communication will not be manifested just once.
- (4) Contrast and the Working Principle of Reasonable Alternatives--there is no way to understand a signal that does not involve recognizing what that signal is not as well as what it is.
- (5) Relativity of Signal and Noise--we communicate simultaneously in many channels, via many systems.
- (6) Reinforcement Packaging--most of the signals that people transmit to other people are packaged; but in the normal course of events we are apt to respond only to some of the included ingredients, allowing others to pass unnoticed or to register on us only out of awareness.
- (7) Adjustment--continuous recalibration of communicative conventions is always to be expected in transactions between human beings . . . communicating and learning how to communicate go hand in hand.
- (8) The Priority of Interaction--a man knows what he is doing, what emotion he is feeling, what choices of response he is making, only by observing his own behavior via feedback.
- (9) Forest and Trees: The Dangers of Microscopy--lengthy concentration or attention on the one event can easily blow up in significance far out of proportion to its original duration and its actual setting. One must not mistake the five-inch scale model for the fly itself (Pittenger et al., 1960; quoted in Labov and Fanshel, 1977:21-22).

At the heart of the Labov and Fanshel model of discourse analysis is the technique of "expansion." Expansion is an analytic strategy which allows the researcher to synthesize all information which will aid in understanding the production and interpretation of actual discourse. This technique is crucial because it permits the researcher's analysis to transcend the discourse and thus allows the researcher to describe how social interaction is accomplished

through discourse. The expansion process involves four steps. In the first step the analyst expands the meaning conveyed by cues to its nearest textual equivalent. The analyst next expands, or makes explicit, referents of pronouns to other utterances and events in different time frames. In the third step the analyst introduces factual material from other sources, usually other portions of the discourse, ethnographic materials or interactants' biographies. Finally, the analyst utilizes the entire discourse event to make explicit as much of the interactants' shared knowledge as is possible. The following is an excerpt from actual discourse material followed by its expansion:

- R: And so when I called her today I said well when do you plan to come home
 R: When I called my mother today (Thursday), I actually said, "Well, in regard to the subject we both know is important and is worrying me, when are you leaving my sister's house where your obligations have already been fulfilled and returning home where your primary obligations are neglected, since you should do this as head of our household (Labov and Fanshel, 1977:50, minus transcription cues).

The situation is a therapeutic interview between a counselor and a woman patient known as Rhoda. The first thing the expansion technique allows for is establishing the referents of pronouns and other indexical expressions (her = mother; today = Thursday). Then information is gathered from other parts of the counseling session which provides a complete picture of the situation. Thus, through expansion, we see that "And so when I called her today I said well when do you plan to come home" is a gloss for a complex set of circumstances

which are producing conflict between Rhoda and her mother.

There are two major strengths to the Labov and Fanshel comprehensive discourse analysis model. First, the expansion technique forces researchers to sensitize themselves to both the context in which interactants produce discourse and to social and cultural factors and relationships outside of both germane to the immediate interaction. Second, the expansion technique permits challenges from critical readers. That is, alternative interpretations are always possible; expansion is fundamentally an open-ended process.

Discourse analysis permits the detailed examination of the two phenomena discussed earlier, accounts and cultural assumptions. It enables us to locate these patterns in the data and to show how they affect the social construction of medical interviews and treatment decisions. Chapters III and IV contain the application of discourse analysis to doctors' and patients' accounting practices and doctors' use of cultural assumptions about their patients.

CHAPTER III

ACCOUNTING PRACTICES AND THE SOCIAL CONSTRUCTION OF MEDICAL INTERVIEWS

What is involved when we say what people are
doing and why they are doing it?

--Kenneth Burke, A Grammar of Motives

Introduction

Forty-five years ago C. Wright Mills published a seminal sociological work (Scott and Lyman, 1981; Wooton, 1975; Wallis and Bruce, 1983; Perinbanayagam, 1977). Mills (1981:325--originally 1940) argued that sociologists should direct their attention to the language social interactants employ and study "its social function of coordinating . . . action." His article is also important because it represents one of the earliest attempts to explicate theoretically a sociological understanding of social actors' motives during interaction. Presumably since the earliest evolutions of human consciousness people have wondered why others engage in particular behaviors, "what makes" humans do the things they do. By grounding his understanding of motives in Mead's and Dewey's emphasis on humans as symbol-producing creatures, Mills made motives a sociological concern. He defined motives as "typical vocabularies having ascertainable functions in delimited social situations" (Mills, 1981:325). His theoretical position at once rescued the understanding of motives from both a predispositional position, i.e., in terms of needs and

drives and an environmental position, or stimuli outside the individual and directed sociologists to examine the process of social interaction and the context in which it takes place.

The purpose of this chapter is to investigate the form and function of motive vocabularies as they occur in a delimited social situation, the medical interview. I will begin by briefly reviewing what I will call traditional sociological work on motive vocabularies. I will then show how the traditional work may be informed and expanded by ethnomethodological considerations. The medical interviews will next be analyzed using the expanded framework. Finally, I will show how the motive vocabularies doctors and patients produce influence the medical interview and, hence, the social construction of reality.

Traditional Sociological Work on Motive Vocabularies

Traditional sociological work on motive vocabularies focuses on normative behavioral expectations and subsequent deviations from them. As Mills (1981:328) originally noted, motive vocabularies function to "integrate one man's actions with another, and line conduct up with norms." That is, interactional participants enter each and every social situation with, to a greater or lesser degree, knowledge of the normative constraints which inform and influence their behavior. Most research addresses itself to the motive vocabularies social actors employ when they have violated social norms, how they "account" for their untoward or deviant behavior. The foundational theoretical assumption is that even if social actors

are not perfectly socialized to conform to all norms in all situations, they are at least sufficiently socialized to realize the potentially negative consequences of their deviance and seek to "account" for this deviance. In so doing they reaffirm both the normative framework and their commitment to it.¹

Perinbanayagam (1977) has observed that traditional sociological work on motive vocabularies or accounts (which has become the popular term) may be divided into three categories, first-, second- and third-person. Social actors may offer first-person accounts during interaction in an effort to reduce the stigmatizing nature of untoward behavior in their own minds--in other words, to account to themselves for their own actions. Sykes and Matza's (1957) work on "techniques of neutralization" clearly falls into the category of first-person accounts. Their research uncovered a series of linguistic strategies which juvenile delinquents employed to convince themselves that, even in the face of behavioral evidence to the contrary, they were not such bad (deviant) people.

Social actors utilize second-person accounts in an effort to convince others that their untoward behavior should not be evaluated too negatively. Second-person accounts may be further divided into two subcategories, retrospective and prospective, depending upon whether the account is offered after the occurrence of some deviant

¹Such interactional activity is what has also been termed "aligning action" (Stokes and Hewitt, 1976) and "remedial work" (Goffman, 1971).

behavior or prior to it. Traditional sociological work on second-person retrospective accounts follows the early research of Scott and Lyman (1981, originally 1968). They took Sykes and Matza's earlier work on neutralization techniques and rooted it more firmly in the social interaction process, thereby defining accounts as "linguistic devices employed whenever . . . [social] action is subjected to valiative inquiry" (Scott and Lyman, 1981: 343).

Scott and Lyman argue that accounts may take two basic forms. Social actors may offer others justifications or excuses. In rendering a justification the actor whose behavior has been called into question admits to behaving in an untoward manner, accepts responsibility for it, but attempts to convince others that the behavior was not really "wrong," that there was, in fact, a legitimate reason behind it. The actor may: (1) deny that the impugning behavior caused injury to others (denial of injury); (2) assert that any "victims" of the behavior deserved to be injured (denial of victim); (3) claim that those negatively evaluating the behavior in question are guilty of equally as or more deviant actions (condemnation of condemners); or (4) note that some greater goals or commitments were served as a result of the behavior (appeal to higher interests) (Scott and Lyman, 1981:348-50). When giving justifications, social actors not only attempt to reduce the stigmatizing properties of their actions and render them neutral, but they also attempt to convince others to evaluate them favorably.

Excuses are accounts which allow social actors to divorce themselves from any responsibility for their untoward or deviant behavior. As with justifications, excuses may take several forms: (1) the actor asserts that the behavior in question constitutes an "accident" if it was of an irregular nature, meaning that it was not part of what the actor exhibits as "typical" behavior (appeal to accident); (2) the actor may claim that, had more information concerning the consequences of the behavior been immediately available, he would not have exhibited the behavior in the first place (appeal to de-feasibility); (3) the actor may argue that the untoward behavior was the result of some innate, biological/physical condition over which no control could be exercised (appeal to biological drive/condition); or (4) he may request to be excused from responsibility by indicating that others are at fault (scapegoating) (Scott and Lyman, 1981:345-48).²

In addition to their discussion of justifications and excuses as forms of accounts, Scott and Lyman (1981:355), drawing on the earlier work of Joos (1961), observe that accounts may be offered in different linguistic styles. The styles are intimate, casual,

²A remaining category of accounts is the "sad tale," wherein the actor offers a particularly dismal rendering of his/her "biography" (Goffman, 1974), sometimes rearranging and/or distorting "facts" in order to explain the behavior in question. The sad tale could be given as a justification or as an excuse, depending upon whether responsibility for behavior in question was accepted or denied.

consultative, formal and frozen. They are distinguished from one another on the basis of a decreasing level of social intimacy between actors. The intimate style is usually evidenced between actors sharing a deep personal relationship (wife-husband, lovers, etc.). The closeness of the relationship allows for a type of "shorthand" accounting, wherein a single word or sound may represent a fully explicated account. The casual style is employed among in-group members and social peers. It typically utilizes slang and evidences that the actors involved share certain background information that makes their jargon unintelligible to outsiders. The consultative style is usually employed when an actor must "fill in" certain background information in order for others to understand the account. The formal style of accounting occurs when an actor must account to a group of people, such as an audience. This style is also often exhibited between actors in rigidly defined social statuses; for example, a prospective employer and a job applicant during an interview, a judge and a defendant during a trial, or a doctor and a patient during a medical consultation. Finally, the frozen style is employed when barriers of a physical or a social nature exist between the interactants.³ Examples, include a captive's recitation of "name, rank and serial number" to his/her captors and accounts "frozen" in the form of newspaper articles (Scott and Lyman, 1981:354-55).

³See Goffman (1959, 1981) for discussions on barriers to communication.

The other type of second-person account is prospective--offered by social actors before they say or do something that others may evaluate negatively. The sociological work on prospective accounts is exemplified by Hewitt and Stokes (1975) in their research on "disclaimers." Hewitt and Stokes (1975:1) define disclaimers as "verbal devices employed to ward off and defeat in advance doubts and negative typifications which may result from intended conduct." They indicate five types of disclaimers which are available to social actors: hedging, credentialing, sin licenses, cognitive disclaimers and appeals for the suspension of judgment.

When actors engage in hedging they provide listeners with brief prefaces to statements of fact, opinion, positions in arguments, etc., which will allow them to "get off the hook" should what they are about to say become problematic. Examples might include, "I'm no expert, of course, but . . .," "I really haven't thought this through very well, but . . ." or "I could be wrong on my facts, but I think . . ." Hewitt and Stokes argue that this type of disclaimer signals an actor's minimal commitment to what she/he is about to say. More importantly, it also signals that the actor is aware of a possible negative evaluation from others and seeks to provide warning that should what is about to be said be taken wrong, the actor really did not have much invested in it anyway.

When an actor employs credentialing she/he is signaling to others that even though what is about to occur will surely be negatively evaluated, she/he remains strongly committed to it.

"I know what I'm about to say sounds juvenile, but . . ." and "I'm not prejudiced, but . . ." would be examples of credentialing. Sin licenses are but a stronger version of credentialing. They signal that an actor is absolutely certain of a negative response or evaluation, but does not care what anyone else thinks (e.g., "I know this is against the rules, but . . .")

Cognitive disclaimers evidence an actor's fear that others may define him/her as "out of touch with reality" based upon what is about to be said. An example might be, "I know this sounds crazy, but I think I just saw . . .". Finally, an actor may rely on an appeal for the suspension of judgment. In this type of disclaimer the actor implores others not to interrupt or react until the full meaning or import of what is about to be said becomes clear (e.g., "Hear me out before you get mad . . ." or "Let me finish before you say anything . . .").

The final category is the third-person account. This category is represented by the work of Blum and McHugh (1971). Their main concern is with how social actors account for the untoward or deviant behavior of others. They argue that actors routinely employ accounts to fill in information about others' behavior, to stand "as the observer's rule for deciding the normatively ordered character of behavior" (Blum and McHugh, 1971:99). That is, third-person accounts are "sense-making" mechanisms which aid actors in the organization of their everyday experiences. For instance, upon reading a newspaper article about a lovers' quarrel which resulted in violence and death,

we might respond, "He must have killed her in a fit of jealousy," or "She must have shot him because he was about to hit her." In both cases we, as non-witnesses/participants in the situation, provide what we assume to be understandable motive vocabularies on behalf of the untoward party.⁴

In addition to continual references to normative behavioral expectations, traditional sociological work on accounts shares another common thread. All work, whether concerning first-, second- or third-person accounts contains the underlying theoretical assumption that accounts are related to actors' social identities (Stone and Farberman, 1981:320; Strauss, 1959:46, Blumstein et al., 1974:565; Bruce and Wallis, 1983:65). Scott and Lyman (1981:357) emphatically argue that "every account is a manifestation of the underlying negotiation of identities." Since the formation and maintenance of social identities is forged during the process of social interaction (Strauss, 1959; McCall and Simmons, 1966), it makes sense to conclude that, given the information accounts present about social actors vis-a-vis the normative structure of situations, accounts do indeed play a role in the negotiation of social identities.

⁴Another work generated within the area of motive vocabularies is Hewitt and Hall's (1973) research on "quasi-theories." It does not fit neatly into Perinbanayagam's typology, but rather seems to be an over-arching orientation, a "world-view" basis for accounts that could be seen as providing a particular direction for first-, second- or third-person accounts. See also Giddens (1977) for a slightly different treatment of accounts that emphasize tacit knowledge among interactants more than what is actually said between them.

Accounts may also be seen as an "impression management" technique (Goffman, 1959). They represent a social actor's attempt to present himself/herself in a certain light to others, to convey a favorable "public identity" which is congruent or compatible with the actor's "personal identity" (Lynxwiler and Groce, 1981:5). The use of personal identity here refers to an actor's evaluative perception of self, the perception of the distinctive organization of personal traits such as appearance, mannerisms, habits, motives and social statuses which are gleaned through interaction with others (McCall and Simmons, 1963).⁵ Since "A person's picture of himself is indissolubly linked with his experiences in social relationships" (Miller, 1963:671), public identity may be taken to represent the evaluative perceptions which other social actors have of the actor based upon normative definitions of social statuses and their accompanying role expectations. During interaction actor will utilize accounts as a means for neutralizing untoward behavior as perceived by other. That is, actor attempts to maintain congruence between personal and public identities called into question by the untoward behavior (Lynxwiler and Groce, 1981).

A review of literature indicates a paucity of studies which explore the nature of accounts in different social situations (Bruce and Walls, 1983; Minor, 1980). Quantitative efforts have been limited

⁵This treatment of personal identity closely parallels Goffman's (1963) use of "ego identity."

either to accounts offered in hypothetical situations or to accounts generated by society's most deviant actors, criminals. Felson and Ribner (1981) explored accounts given by male offenders convicted of homicide and assault. Their findings indicate a predominance of justifications over excuses, especially when evidence of personal causation exists. Blumstein et al. (1974) investigated a set of variables believed to influence people's acceptance or rejection of others' accounts. They concluded that the moral worth of the offender, his/her status relative to the status of the person demanding the account and the seriousness of the accountable offense were all significantly related to the honoring of an account.

Qualitative research usually focuses on the types of accounts offered in particular social situations. Morris (1976) studied the treatment by the press of the Women's Movement in the late 1960's. She analyzed the contents of articles, editorials and cartoons in an attempt to apply Scott and Lyman's accounts typology. Her findings indicate that newspaper editors rely more heavily on justifications than on excuses, attempting to "reason with their critics . . . to save face, to maintain credence within acceptable limits of good business and tact" (Morris, 1977:113). Lynxwiler and Groce (1981) examined the accounts offered by surface coalminers in response to the violation of land reclamation regulations. They concluded that officials from larger coal companies tended to justify their infractions while small company officials tended to excuse themselves. Finally, McCall (n.d.), in a study of the accounts offered for the

dissolution of intimate relationships, has documented that accounts may be both multiple and repeated.

The traditional sociological work on accounts has suffered from a number of problems. Extant research has failed to produce any substantive and generalizable conclusions (Minor, 1980). There is always the problem of categorizing accounts. What may clearly appear to be a justification in one situation may just as easily become an excuse in another situation (Wooton, 1975; Bruce and Wallis, 1983). Furthermore, traditional work on accounts evidences a lack of conceptual clarity concerning the types of deviance for which actors account (Lynxwiler and Groce, 1981; Groce and Fisher, 1984). Research focuses almost exclusively on the types of accounts actors offer for deviant behavior with far-reaching consequences (murder, assault, etc.). We know, however, that the concept of deviance spans a wide range of possible behaviors, many of which have less than legally-serious consequences.⁶ As Goffman (1971:x) has noted:

When persons engage in regulated dealings with each other, they come to employ social routines or practices, namely, patterned adaptations to the rules--including conformances, by passings, secret deviations, excusable infractions, flagrant violations, and the like.

⁶According to Schur (1971:24): "Human behavior is deviant to the extent that it comes to be viewed as involving a personally discreditable departure from a group's normative expectations, and if it elicits interpersonal or collective reactions that serve to 'isolate,' 'treat,' 'correct,' or 'punish' individuals engaged in such behavior."

Furthermore, Felson and Ribner (1981) and Scott and Lyman (1981) argue that actors will account for themselves when exhibiting violations of conversational rules as well as violations of legal codes; Hewitt and Stokes (1975) add that we should investigate accounts for violations from the trivial to the serious; and Perinbanayagam (1977:106) simply concludes that accounts "are essential and inevitable aspects of a human being engaging in the ordinary course of his life."

Accounts as Interactional Process

In addition to the problems facing traditional sociological work on accounts discussed in the previous section, one more must be addressed. This problem centers around the inability of the earlier work to explore the process of accounting during social interaction (Groce and Fisher, 1984:2). By focusing strictly on the structure of accounts, whether accounts are justifications or excuses, traditional work separates accounts from the very interactional contexts in which social actors produce them. When researchers examine accounts in this manner, they treat accounts as if they occurred in a vacuum and the interactional work which accounts do gets lost. Consider the case of the "identity work" done by accounts. Traditional work accepts as a theoretical postulate that accounts represent the negotiation of social identities. The interactional context is seldom, if ever, examined to display how this identity work is actually accomplished.

One way to broaden our conceptualization of accounts to include the process of accounting is to incorporate ethnomethodological considerations into the traditional framework. As Schwartz and Jacobs (1979:47) have observed, by examining the process of accounting we may arrive at

a more sophisticated appreciation of the significance of "accounts." These should not be regarded in advance as "information," which is either "true" or "false," depending on how it compares to some "referent" "out there." Instead, an effort must be made to ascertain the purposes, understandings, and activities which the members associate with the accounts they give. That is, one must find out . . . the procedures respondents use [emphasis in original].

A greater appreciation of the process of accounting may be obtained by considering Garfinkel's (1967) contention that all social phenomena are "account-able." Any social situation is organized, or appears to be organized, because that situation consists of interactants' organized methods or procedures for accounting for that situation as being organized. Or, as Garfinkel argues (1967:1): "the activities whereby members produce and manage settings of organized everyday affairs are identical with members' procedures for making those affairs 'account-able.'" So, then, if accounts are fundamental features of all social situations, the process by which interactants produce and accept accounts becomes a fundamental process in the social construction of reality (Handel, 1982:39).

The relationship between accounts and the social construction of reality is made clearer by considering the related concepts of reflexivity and indexicality. In terms of logic, the relationship

anything has with itself is reflexive. Reflexivity is used grammatically in a similar manner. If "John washed himself this morning," "washed" is a reflexive verb because its subject and object are the same (John, himself). Ethnomethodologists argue that talk itself is a reflexive phenomenon (Cicourel, 1973; Garfinkel, 1967). All accounts, then, must be reflexive (Handel, 1982:35). Accounts are reflexive because they are "embedded in the very reality that they characterize, record or structure" (Tuchman, 1978:189). For example, a fundamental component of two people "having a good time" is their talking about it, their making it "account-able," their interactional production of the event itself. In other words, an account "not only delivers some particular information, it also creates a world in which information itself can appear" (Mehan and Wood, 1975:12).

As all accounts are reflexive, so too are they indexical (Handel, 1982; Tuchman, 1978; Giddens, 1977). Indexicality refers to the contextual embeddedness of accounts. That is, the meanings actors construct and produce when giving accounts are dependent upon the situational context in which the accounts occur. For instance, the utterance "It's raining," appears on the surface to have unambiguous meaning. However, when the context surrounding "It's raining" changes, so does the meaning of the utterance. For a farmer to speak the phrase after a two-month draught means one thing; for a driver whose car has no windshield wipers to say "It's raining" means something entirely different. As Handel (1982:43) observes, indexicality allows for an account "to have all other information

as its context and be the context for all other information." Hence, indexicality implies reflexivity and vice-versa (Tuchman, 1978:198). These two properties of accounts taken together provide the basis for treating accounts and the process of accounting as a central feature of the social construction of reality.

The Structure of Accounts in Medical Interviews

In this section I will examine the types of accounts doctors and patients provide for each other during medical interviews. I will employ an amended version of Scott and Lyman's (1981) typology to discuss the structure of accounts. I will retain their categorization of excuses; to their classification of justifications I will add an account observed by ethnomethodologists Shumsky and Mehan (n.d.). They call the account an appeal to the informed person justification. When giving this account a social actor appeals to his/her own (claimed) expertise or knowledge on a given subject.

The data display a seemingly strong patient preference for the use of justifications during medical interviews. Of the 105 patients' accounts recorded and coded, 77.1 percent were justifications.⁷ There were no instances of denial of injury, denial of victim or condemnation of condemners' justifications. The majority

⁷I coded accounts based on Scott and Lyman's criteria. Utterances were coded as accounts if they provided explanations for deviant behavior. There were no checks for coder reliability.

of justifications were appeals to the informed person (51 or 62.9 percent). The typical form of the patients' appeal to the informed person is indicated by the following examples:⁸

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: why don't we just stick with the X-ray up here okay	P: okay	
D: alright the nurse will come and get you in just a second and take you around to x-ray and if I were you I'd keep on using these crutches okay	P: okay	
D: just set them over here		
P: I figured it was a good idea to get the weight off of it		
	(#28, p. 3)	
D: what brings you to us today	P: well it's my feet uh they began hurting me about 16 months ago and uh you know they just hurt and stop hurting I just wouldn't I thought it would go away you know the way you things//and in	D: //uhm

⁸Excerpts quoted here and elsewhere are from twenty of the forty-three medical interviews (46.5 percent). Numbers and page numbers in parentheses refer to the transcribed interviews.

the fall of the year
it seems to ease up
pretty good and
during the winter
months it wasn't too
bad but then it
started back and
seems like it's worse
now than it was

(#30, p. 1)

In the first example the patient accounts for the atypical behavior of walking on crutches. The behavior is atypical or deviant because doctors are usually the ones who put patients on crutches, not the patients themselves. The patient apparently realizes this and appeals to himself as an informed person by explaining to the doctor: "I figured it was a good idea to get the weight off of it." The patient in the second example relies on the informed person justification to account to the doctor for deviance of another kind--the failure to see a doctor as soon as a problem develops. He explains the sixteen-month wait between the onset of the problem and his visit to the doctor by saying that he thought the problem would simply go away.

The only other type of justification evidenced in the data was the appeal to higher interests. Patients employed this account slightly more than half as frequently as the appeal to the informed person (30 or 37.1 percent). The following excerpt illustrates the typical form of the appeal to higher interests:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: and if you're no better in a week then just come back see me alright uh your lungs sound clear your shoulder seems to work okay and I probably what is just a muscle back there alright so uh I'll get you that and you can you need an excuse to you know that you were in here to see a doctor	P: no I work for myself so//	D: //oh do you okay

(#33, p. 3)

The doctor is summing up, reviewing what has gone on earlier in the interview. In concluding he asks the patient if a formal account (a doctor's excuse) is necessary in order to explain the deviant behavior of missing work. The patient supplies his own account, appealing to higher interests by telling the doctor that an excuse is unnecessary because he works for himself.

Patients accounted for deviant behavior significantly less frequently with excuses than with justifications. Only twenty-four (23.1 percent) of patients' accounts were excuses. Patients used the appeal to accident excuse more than any other (37.5 percent of total excuses). The typical appeal to accident looked like this:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: okay the doctor said they may be cataracts	P: yeah he said me did I did have cataracts uh what happened I had gotten some uh open a jug of ammonia to man in fact my head was going to pop off	

(#40, p. 6)

In this instance the patient is accounting for problems with his eyes. He excuses himself from responsibility for his condition by appealing to an accident. He asserts that he is not to blame; the incident with the jug of ammonia caused the condition.

Appeals to biological drives or conditions were almost as prevalent as appeals to accident in patients' excuses. They comprised 29.2 percent of the total number of excuses. Typically, patients employed this excuse in accounting for why they came to the clinic that day:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: let me sit here what brings you to us today	P: well I need some- thing for fluid// uh regular diet pill or fluid pill won't work on me	D: //uhhuh
D: what do you mean when you say you need some- thing for fluid I'm not sure I under- stand	P: I'm retaining quite a bit of fluid I'll take off my shoe and	

you can see how
my feet are swollen D: yeah

(#35, p. 1)

The patient is accounting for the atypical or deviant behavior of coming to the clinic. He is an extremely large man who weighs approximately four hundred pounds. He excuses himself by appealing to a biological condition--the retention of body fluid.

The data revealed only four instances each (16.7 percent) of appeals to defeasibility and scapegoating. Typically, the appeal to defeasibility surfaced as an account for why a patient had not followed a medical regimen prescribed by another doctor. Patients usually intimated that had the doctor explained more fully what to do or had the patient understood what the doctor was saying, the treatment decision would have been followed. Patients employed scapegoating when accounting for "lay treatment decisions" reached without medical advice. The typical response was: "Jack said I'd get better if I did this or took this medicine." In both cases patients attempted to divorce themselves from responsibility for their deviant behaviors.

Much of the sociological work on accounts (Scott and Lyman, 1981; Blumstein et al., 1974; Sykes and Matza, 1957; Felson and Ribner, 1981; Groce and Fisher, 1984) has focused exclusively on how the "significantly deviant" actor in a social situation accounts to the "significantly conforming" actor. Whether it be women patients accounting to doctors of juvenile delinquents accounting

to legal authorities, the underlying assumption seems to be that only one party to the interaction, presumably the deviant one, actually offers accounts. This is a noteworthy omission for, as discussed earlier, accounts are a ubiquitous feature of the social construction of reality. All social actors account for their actions because in the course of an interactional sequence, all actors exhibit some deviant behaviors.

It is not surprising then that the present data reveal an interesting set of doctors' accounts to their patients. While doctors offered less accounts than patients, their division between justifications and excuses was similar to patients' (doctors gave 70 percent justifications and 30 percent excuses; patients gave 76.9 percent justifications and 23.1 percent excuses). A fundamental difference in doctors' and patients' accounts is seen in the types of justifications offered by both. Whereas patients gave informed person justifications most frequently, doctors' most often used justification was the appeal to higher interests (26 or 74.3 percent). Doctors employed appeals to the informed person only 20 percent of the time. The following examples illustrate doctors' appeal to higher interests and appeals to informed person accounts:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
P: I apologize for the procedure that had to be taken	D: oh listen that's uh my job you know	
P: I know but it's uh not one of the more		

uh pleasant things
you do

D: it's a whole lot
less pleasant for you
having it than it is
for me treating it
believe me and uh but
likely it they say it
can be treated

(#18, p. 2)

D: so I think we just
ought to check a few
chemistry values to
check and see what's
going on//alright I
also like to get another
blood count because
this can also
be caused by low
platelet count//or
low red blood count so
it could be something
other than the liver
it could be nothing//
'cause I've seen
patients where I can't
turn anything up but
they have that problem
anyway

P: //fine

P: //uhhuh

P: //right

P: sure

(#8, p. 12)

In the first example the patient's presenting complaint was a collection of cyst-like bumps on his penis. The doctor had just completed a genital exam and had diagnosed the bumps as venereal warts. The patient apologizes for causing the doctor to conduct the exam. Notice how the doctor appeals to higher interests in his account. He emphasizes that since venereal warts are treatable, the inconvenience of the genital exam is overshadowed by the potential for treatment and cure.

The second example differs from the first because the doctor here cites his own personal knowledge and expertise (gained from experience) with the patient's condition. The patient's problem is an enlarged liver. While the doctor's diagnosis has been non-specific, he still feels that more tests should be performed. To account for the inconvenience (deviance) of keeping the patient at the clinic longer than he expected, the doctor explains to the patient what he knows about the condition and in the process legitimates further testing.

A significant difference may be seen in the types of excuses doctors and patients give each other. Although both groups employed appeal to accident with about the same frequency (doctors = 40 percent; patients = 37.5 percent), we see a sizable difference in the use of appeals to defensibility. Patients gave appeals to defeasibility 16.7 percent of the time, while doctors gave them 40 percent of the time. As the following examples indicate, doctors seemed to utilize this account when they were at a loss to explain certain medical conditions:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: but uh it it's a dermatofibroma//and it's uh benign kind of thing . . .		P: //okay
P: is that right	D: yeah//but that's what it is just a little bit of fibrous tissue that got buried under the skin	P: //uhm

uh for reasons that
we don't understand
really P: uhm

(#3, p. 1)

D: did it come on you
gradually or just
all//suddenly one
day notice P: //just sorta
notice
P: yeah this morning
I noticed it just
when I got out of
bed D: yeah

D: I I will be honest
with you I'm at a
loss to tell you
exactly what it
might be

(#7, p. 5)

In the first example the patient presents with a small cyst on his neck. Earlier in the interview he voiced concern that it could possibly be malignant. The doctor explains that it has about a one in ten thousand chance of being malignant and then goes on to account to the patient for his inability to explain exactly where the cyst came from. He excuses his ignorance about the cyst by saying, "for reasons we don't understand really," suggesting that if he had more information available to him, he might be better able to explain the condition. The second example is similar to the first. Here, the patient presents with low abdominal pain and states repeatedly that he feels the problem to be a hernia. The doctor rules out the possibility of a hernia, but at the same time fails to diagnose the condition. He attempts to excuse his deviance by appealing to defeasibility: "I'm at a loss to tell you exactly what it might be."

The Interactional Accomplishment of Accounts

Earlier I proposed the utility of incorporating an ethno-methodological perspective into the traditional accounts framework. Since accounts do not occur in a vacuum, but rather are the result of socially situated action, a broadened conceptualization of accounts advises us to explore the process through which social actors accomplish the giving of accounts during interaction. The data permit the identification of two basic accounting forms utilized by patients and doctors to get information on the floor: volunteered accounts and requested accounts. For patients, the most prevalent form is the volunteered account which comprises 78.1 percent of the total number of patients' accounts. The volunteered account may provide either medical or social information. It typically occurs as part of an overall response to the doctor's request for information. That is, the doctor does not directly call for an account; rather, the patient, after providing the information requested by the doctor, appends an account to the end of the response. The characteristic structure of a patient's volunteered medical account is seen in the following excerpt:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: how long has this been going on now	P: oh I'd say for may- be 6 months you know somewhere in there and uh they gave me some prescriptions I got this medicine I didn't take them	

every 4 to 6 hours
 but I misunderstood
 don't know whether I
 should take them all
 the time or just when
 I have pain

(#40, p. 1)

This exchange occurred as part of a discussion about the patient's presenting complaint. The patient had come to the clinic complaining of weight loss, stomach pains, constipation and vomiting. The doctor's question, "How long has this been going on now?" pertains strictly to the patient's stomach pains. The doctor is not requesting an account; he is merely trying to establish the duration of the patient's stomach pains. The patient provides the requested information, "Oh, for I'd say maybe six months, you know, or something in there," and continues volunteering an appeal to accident--he had some medicine but didn't take it properly because he misunderstood.

A volunteered social account differs from a medical account in that the patient provides information which is not directly medical in nature. Typically, patients offer this social information as an account for some medical problem or condition which is currently the topic of conversation. The following example illustrates the volunteered social account:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: I'm Dr. _____ why why don't you go ahead and sit up there what can I do for you	P: well I got a bad ear problem	

D: you do

P: I do and in my
profession I can't
afford it

(#22, p. 1)

In this instance, as before, the doctor is not directly calling for the patient to account for himself; he is attempting to discover the nature of the patient's presenting complaint. After the initial question and answer sequence the doctor responds to the patient's response that he had a bad ear problem with another question: "You do?" The patient provides the requested information in the form of an appeal to higher interests justification. He accounts by saying that in his job one cannot afford to have ear problems. In a subsequent discussion the patient reveals that he is a bass guitar player in a local rock and roll band. He has grounded his account for seeking medical attention in another social situation.

Patients also volunteer accounts when they are in control of the floor. They use this control to provide information even though the doctor has not requested any. The characteristic structure of patient's initiated volunteered accounts is revealed in the following excerpt:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: no problem with your legs uh giving out on you	P: no	
D: other than the knees	P: other than the knees is the only problem and he just said that I was trying to make a 46 46 year old	

knee perform like a
16 year old's

D: that that
sounds probably
right sure
does

P: I think that's the
problem with this
right one I think
it's just the fact
uh it's been asked
to do things it'
mind//and the knee
says no

D: //possibly

(#15, p. 8)

Here, although the doctor is apparently satisfied with the information the patient has provided in response to his questions, the patient seeks to provide more. He takes the floor, providing both additional information and, in this case, a medical account (justification, appeal to informed person).

Not all patients' account in the data were volunteered. Patients also provide accounts in response to doctors' specific requests for them. The data reveal that requested accounts occurred almost four times less frequently than did volunteered accounts (21.9 percent to 78.1 percent of total accounts). The requested account begins with the doctor calling for information on a specific medical or social topic. The request for an account differs from a general request for information in that the doctor, when requesting an account, typically asks questions beginning with, "Why . . .," "How did you . . ." or "What made you decide to" The patient then responds by providing an account, as the following example illustrates:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: what did it feel like	P: whew well its hard to explain how it felt it just//	
D: //was it chest pain	P: right uh I had a hard time breathing of course you//	
D: is that just recently or do you always have a hard time breathing why didn't you come to the hospital what you're describing to me are symptoms of a heart attack	P: right	
D: is that what you expected	P: yeah	
D: why didn't you come to the hospital	P: 'cause I went to the hospital they I know my system and I know what I can do with it and uh last time I had one they put me in the hospital I like not to got out	

(#35, p. 2)

In this example the doctor is gathering medical information. As the patient responds to his questions the doctor begins to realize that the patient may have had a heart attack. Since the patient has come to the clinic a week later still complaining of complications, the doctor, in an almost incredulous tone, requests an account: "Why didn't you come to the hospital?" At first, no account

is forthcoming; the doctor recycles his request for an account. The patient finally provides the requested information by giving an excuse--scapegoating. He implies that his previous visit to the hospital almost killed him because the staff didn't know his system as well as he did.

The data reveal that doctors exhibit a very different pattern of accounting strategies than do patients. Of the fifty accounts offered by doctors, 96 percent (48) were volunteered. None of these volunteered accounts were appended onto other information given in response to patients' questions. Doctors always took the floor to initiate accounts, as illustrated in the following example:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: hello	P: howdy	
D: Tony how do you pronounce the last name	P: Kowalski	D: okay
D: I'm sorry I'm a little late I had one that just kept me tied up and I couldn't get in I'm sorry to keep you waiting how long have you been waiting	P: oh 5 or 10 minutes	D: okay that's not terribly bad

(#11, p. 1)

The doctor has been detained with another patient. After establishing the pronunciation of the current patient's name, he takes the floor to volunteer an account for keeping the patient waiting--he had

a patient that kept him "tied up" and he couldn't get in.

Responses to Accounts

Since the giving of accounts is an interactional accomplishment in the on-going social construction of reality, it makes sense to explore what happens to accounts once they are produced. In other words, another facet of socially constructed reality is actors' responses to others' accounts. The data reveal a set of doctors' responses to both volunteered and requested patient accounts. These responses seem to function as social control strategies which allow doctors to control interaction by controlling the flow of information. The result is that doctors control the medical interview itself (Hughes, 1982; Fisher, 1983; Shuy, 1983)--a control which has been demonstrated to have serious consequences for the delivery of health care (Fisher, 1983; Fisher and Groce, 1985).

Doctors' responses to patients' accounts take the following forms: acceptances, rejections and no responses. In an acceptance the doctor openly agrees with or accepts the patient's account. In the data, doctors accepted their patients' accounts only 23.8 percent of the time. The typical acceptance of an account reveals the following structure:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: you must have been skin and bones	P: I was wore out from working and smoking and I just can't I was sick	

and I needed a
change and it was
easy to quit if I
had a challenge and
I just accepted it
I've never craved a
cigarette after 3
days

D: that's great

D: let you sit up now
everything looks
wonderful on the exam
I don't see any problem
on//uh and a few
screening tests should
help me really explain
any risk factors you
have . . .

P: //okay

(#42, p. 13)

In this example the doctor and patient are discussing the patient's cigarette smoking history and weight loss. When the doctor remarks, "You must have been skin and bones," the patient replies with an account--he was worn out from working and smoking and felt like a change was in order. The doctor accepts the account with an emphatic, "That's great!" At first glance, the way in which this acceptance functions as a social control strategy may not be apparent. This exchange occurred in the closing phase of the medical interview--the phase in which the doctor is typically concerned with summing up his findings and formulating a treatment decision. Thus, the institutional authority of the doctor's role is revealed in his acceptance. Upon exclaiming, "That's great!" he immediately takes control and directs the conversation back to the medical task at hand. He sums up and begins to discuss what other procedures might be necessary.

A less frequently employed response to accounts is the rejection. The data indicate that doctors openly rejected 6.7 percent of their patients' accounts. All of these rejections were for accounts which patients volunteered; doctors openly rejected none of the accounts they had called for themselves. The typical rejection is displayed in the following excerpt:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: let's uh do one thing right now I always get uh a chest x-ray to see if possibly you've got some abnormal structure in your bone at the base of your neck uh impinging upon the arteries going down to your arms okay it's called thorascic outlet syndrome that's possibly uh you this could be a cause for your trouble if not we can probably consider getting some nerve conduction studies on you to see if there's anything wrong with the nerves to your hand okay	P: yeah	
P: I knew this fiddle player and the way I talked to him and the way he talked to me sounds like we've got about the same thing they call his tendonitis man he was 30 years older than I am	D: well tendonitis	

can strike at any
 age usually you get
 tendonitis from an
 impingement or an
 irritation of the
 tendons tennis elbow
 you get from right
 here you get a car-
 potomal syndrome
 right in here but
 your pain goes all
 the way up to here
 right//there's no P: //uhhuh
 difference from
 here to here

D: okay do you ever get
 any pain right there
 in your wrist

P: nuhhuh

(#2, p. 8)

As in the previous example, this exchange takes place in the closing phase of the medical interview. The doctor is explaining to the patient the probable cause of the patient's reduced sensation in his hand. The doctor asks the patient if it is all right to do some more tests. The patient replies in the affirmative and then takes the floor to volunteer an informed person medical account--he feels like it might be tendonitis. The doctor rejects the account through a technical explanation of the differences between tendonitis and the patient's present condition. The doctor then directs the interview back to the patient's problem and seeks more relevant information. The social control functions of rejections is particularly evident when we consider that 87.5 percent of the rejected accounts were appeals to the informed person, wherein the patients attempted to render diagnoses of their own conditions. It is as

if there is an unwritten rule influencing the organization of communication during medical interviews: patients are not to attempt to "take the role of the doctor" and construct medical diagnoses. The medical setting vests doctors, not patients, with the institutional authority to make diagnostic decisions. It is not too surprising, then, that doctors routinely reject informed person justifications.

The most prevalent and yet most subtle response to patients' accounts which doctors employ is to simply give no responses to what has just been said. The no response strategy accounted for 70.5 percent of all doctors' responses to patients' accounts in the data. One way in which doctors may fail to respond to patients' accounts is to change topics immediately after a patient has provided an account, as follows:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: now when was this	P: it's been about 4 or 5 weeks ago// or longer//there is another germ I heard of that certain types of medicines have to get next to it and it's not exactly uh hu let's see now I can't name all of them gonorr- hea germs but they is a gonorrhea germ that is a chicamauga or some kind of mauga germ in there that certain types of medicine I forgot// have to reach	D: //4 or 5 weeks ago //okay
D: //okay let me let me let me ask you a few questions uh the sensation that you're		

having right now uh
do you feel like you
have to go to the
bathroom more
frequently//
than usual

P: yes

P: //uhhuh

(#21, p. 3)

On the surface the reader might be inclined to argue that the doctor has accepted the patient's account. After all, he did say "okay" after the patient offered an informed person account for his presenting complaint, a burning sensation in his penis. However, the doctor's "okay," rather than functioning as a token of agreement, functions to subtly allow no response to the actual account. "Okay" functions as a transition marker which gives the doctor control of the floor and leads the conversation back to the presenting complaint. Notice how forceful the doctor was in re-establishing his control. Immediately after his "okay," he repeats his initial phrase three times before he continues: "let me, let me, let me ask you some questions" The doctor has allowed this account to pass by neither accepting it nor rejecting it. He has exercised social control by returning the discourse to a purely information-based exchange. It is as if the doctor is orchestrating a "medical interview tune" which the patient does not "hear," but is forced to dance to nonetheless.⁹

⁹The reader may wonder if what the doctor is actually doing when he does not respond is ignoring the patient and his account. While that is a distinct possibility, in this and other instances in the data it is purely speculation. "Ignore" in our culture is

Doctors may also fail to respond to patients' social accounts as they control the topic under discussion. Rather than changing the topic, the doctor in the following example does not respond to the social information the patient provides and returns to the medical information on the floor. Again, the account is neither accepted nor rejected; the doctor treats it as if it had never occurred.

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: I'm Dr. _____ why don't you go ahead and sit up there what can I do for you today	P: well I got a bad ear problem	
D: you do	P: I do and in my profession I can't afford it	
D: tell me about it	P: well Sunday it started hurting// Monday it it this ear here got sore so sore I couldn't touch it	D: //uhhuh D: //oh really

(#22, p. 1)

The topic here is the patient's presenting complaint, an ear problem. After the patient tells the doctor about the problem, the doctor questions him by asking, "You do?" The patient restates that he

generally understood as pejorative. It also seemingly implies a conscious choice by the person who is ignoring someone or something. The data simply do not permit conclusions about what goes on in doctors' heads. Hence, the label "no response" for the pattern indicated by the data.

does have an ear problem and adds an appeal to higher interests social account: in the patient's line of work he cannot afford to have ear problems. The doctor does not respond to the account when he says, "Tell me about it"--meaning the ear problem, not the patient's occupation. The patient capitulates by beginning his story about the ear problem. The doctor has not acknowledged the patient's social account; it is as if the patient had never volunteered one. The institutional authority of the doctor's role is apparent here as the doctor keeps the conversation on what medical practitioners define as relevant. Although the patient's account that in his line of work he can't have ear problems could be very relevant, especially from the patient's point of view, it is the medical definition of relevance which stands (Todd, 1983).

We see quite a different picture when we examine how patients respond to doctors' accounts. While patients have available the same array of possible responses as doctors did, their response pattern is markedly different. Of the fifty accounts offered by doctors in the interviews, patients accepted thirty of them (60 percent as compared to the 23.8 percent acceptance rate by doctors for patients' accounts). Interestingly, many of the patients' acceptances were far more complex than those of their interactional partners. Rather than uttering a simple "alright," "that's great," or "okay," patients tended to construct more elaborate acceptances, as indicated by the following excerpt:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: where is _____	P: _____ is in//	
D: //he went//up to	P: //Massachusetts University of _____ in _____	D: yeah
D: didn't even register the name didn't even register I'm sorry I've just been going//	P: //that just shows how busy you are	D: yeah (laughs)
D: I've been going from door to door//that's why I'm late getting to you	P: yeah that's alright	D: well very good
D: uh hers was a juvenile onset though		
(#8, p. 3)		
D: excuse me my hands may be cold I just washed them I'm one of those poor souls that cold water (freezes?) my hands	P: it's nice to have something cool on a day like this// be glad to have your cold hands	D: //yeah it is
D: () let's have you look right at me open your mouth real wide for me now		

(#6, p. 3)

In the first instance the doctor has just entered the examining room. He accounts for his deviant behavior (being late) by offering an appeal to higher interests justification--he's been busy going from door to door, presumably examining patients. Rather than supplying

a simple acceptance, the patient accepts by displaying his understanding of the import of the doctor's behavior: "It shows how busy you are." Apparently not satisfied, the doctor recycles the account and the patient once again accepts. In the second example the doctor accounts with an appeal to biological condition excuse-- cold water has always made his hands cold. Notice the complexity of the patient's acceptance. He not only openly accepts the account, but he goes on to explain to the doctor that he should be glad his hands are cold during the summer.

There is also a difference in the structure of discourse following the giving and receiving of accounts between doctors and patients. As discussed earlier, when doctors accept patients' accounts (which is infrequently), they typically then take the floor to either ask more questions or provide more medical information. However, the data indicate that when patients accept doctors' accounts, it is still the doctors who regain control of the floor, even though the patients technically still control it. Such is the case twice in the first example and again in the second. In the first example the doctor takes control of the floor after the patient accepts his account in order to reformulate the account; again, after the patient's second acceptance, the doctor takes charge, this time to direct the discourse back to a medically relevant topic--a discussion of diabetes in the patient's family. In the second case, after the patient accepts the doctor's excuse, the doctor takes the floor in order to begin the physical examination phase of the

interview. This pattern held true for twenty-five of the thirty doctors' accounts accepted by patients (83.3 percent). In only four of the remaining cases did the patient keep the floor to provide information or ask questions; in one case the patient attempted to keep the floor but was interrupted by the doctor.

The incidence of patients not responding to doctors' accounts was considerably less than that of doctors not responding to patients' accounts in 36 percent of the cases--just slightly more than one-half as often as doctors ignore patients' accounts. Once again in the following excerpt, notice how the structure of the discourse is different when doctors volunteer accounts:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: did it come on you gradually or just all//suddenly one day notice	P: yeah this morning I noticed it just when I got out of bed	P: //just sorta D: yeah
D: I I will be honest with you I'm at a loss for to tell you exactly what it might be because I don't find anything ob- jectively why don't you lay down up here on the table and let me just see if I can duplicate it by//		
P: //just lay down	D: yeah just lay down flat now I'm going to try to lift this leg up . . .	

After the patient responds to the doctor's question, the doctor volunteers an appeal to defeasibility excuse. While we could interpret the patient's lack of response to the account as an ignore, a recognition of the doctor's control of the situation suggests another meaning. The structure of the discourse indicates that it is not so much a matter of the patient's non-response to the account as it is a matter of the doctor not allowing the patient an opportunity to respond. The doctor volunteers the account and then uses the opportunity to retain control of the floor and immediately direct the interaction back to medical procedures: "Why don't you lay down up here on the table" Contrast this structure with the structure of the discourse in an instance where the patient does apparently ignore the doctor's account by providing additional information, as follows:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: . . . I'll go ahead and give you a pain pill and a sleeping pill and refill your valium that you've been taking all these years	P: yeah I'm taking that for nerves real nerves	
D: I don't usually use valium but when some- one has been taking it for a long time that's okay uh es- pecially with the problems you've been having with the polio and all valium seems to help loosen your muscles up		

P: well I I never took
any kind of medicine
hardly until I had my
leg busted//
and had these
operations . . .

D: //yeah

(#41, p. 8)

Here the doctor volunteers an appeal to higher interests justification to account for his decision to refill a long-standing prescription for valium. The patient seemingly does not respond to the account by taking the floor to provide the doctor with additional medical information. Patients actually failed to respond to doctors' accounts in this manner in only four cases (22.2 percent). In 77.8 percent of the remaining "non responses," the doctor actually retained the floor and continued with medical questions/statements, thus not permitting the patients an opportunity to respond.

Patients openly rejected doctors' accounts in only two instances (4 percent). In the first case the patient's rejection was followed by the doctor's formulation of another account, as follows:

Initiation

Response

Comment

D: so I think we just
ought to check a few
chemistry values and
see what's going on// P: //fine
alright I also like
to just get another
blood count because
this can also be
caused by low plate-
late count//or low
red blood count so
it could be some-
thing other than
the liver it could
be nothing at all//

P: //uhhuh

P: //right

'cause I've seen patients
 where I can't turn
 thing up but they have
 that problem anyway//
 could be out in the sun
 a lot you know all of
 this can fool you//and
 make you think other
 things

P: //sure

P: //yeah

P: this is seldom
 out in the sun
 you know I keep
 my shirt on

D: okay

D: well I think ought
 to just check these
 chemistries and see
 what we find

P: alrighty fine

(#8, p. 12)

The doctor offers a lengthy account as to why certain tests need to be done. The patient openly rejects the part about being out in the sun. The doctor accepts the rejection ("okay") and goes on to offer another account which the patient finally accepts.

In the second case, the patient's rejection of the account actually affects the treatment decision:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: well I'll tell you have you got in- surance that will cover this or some- thing I tell you I I hate to waste your money x-raying that 'cause I just feel practically sure it's not broken you know if you don't mind if you really want it x-rayed bad I'll I'll x-ray it but it's just my I mean		

if its broken I'm
just going to be
shocked because it
doesn't look broken
to me

P: then what's causing
the pain and//

swelling//

and I can//

D: //well you've got
a bruise

D: //you've got a
bruise

D: //you can get a
lot more swelling
than that from a
bruise

P: I haven't been able
to sleep in 24 hours
and that's unusual
for me//I've got a
high tolerance for
pain

D: //okay

D: well I I'll tell
you what I'll get
it x-rayed then
we'll see you may
be right

(#28, p. 2)

Here, the doctor offers an informed person justification--he feels practically sure the leg is not broken and does not want to x-ray it. The patient challenges him and in so doing rejects the account. The doctor then alters the treatment decision and x-rays the patient's leg.

The most interesting aspect of patients' rejections of doctors' accounts is their infrequency (two rejections out of fifty accounts). Doctors and patients, as competent members of society, have available to them the same set of possible accounts. Yet doctors rejected three times as many accounts as patients did. Presumably, what we are seeing here is once again a manifestation of doctors'

institutional authority. Both parties to the interaction seem to display an understanding of another of the unwritten rules of medical interviews: doctors control the flow of interaction and the medical interview itself. This control manifests itself in doctors' willingness to challenge the information patients give them and to reject it. Patients, too, seem to understand this reality. Their understanding is manifested in their apparent unwillingness to challenge the authority of the doctor.

Accounts and the Structure of Medical Interviews

Earlier I discussed the four-part structure of medical interviews, an opening phase, a medical history, a physical examination and a closing phase. The data indicate an interesting distribution of patients' accounts and doctors' responses to them across these interview phases. The purpose of the medical interview's opening phase is to allow the patient to describe his presenting complaint, to "tell his story." As we would expect, patients giving a lot of information in this phase also provide accounts. Of the 105 total accounts, patients gave thirty (28.6 percent) in the opening phase. Patients volunteered twenty-one of these accounts, while doctors requested the other nine. Interestingly, doctors accepted only three (10 percent) of these accounts. While they did not openly reject any accounts in this phase, doctors did fail to respond to the other 90 percent of them.

The task of the medical history phase involves the doctor probing the patient's medical and social history as well as his

family's medical history. Again, with patients providing doctors with a large amount of information, we would expect to see many accounts. The majority of accounts occurred in the medical history phase (forty-three or 41 percent of total accounts). The data also indicate that doctors are most likely to accept patients' accounts in this phase (ten acceptances, or 23.3 percent of medical history phase accounts). However, doctors are still wont to give no response to accounts in this phase--thirty one or 72.1 percent. Only two accounts (4.6 percent) were rejected in this phase.

Considerably less information passes between doctors and patients in the physical examination phase of the interview. That is because the doctor is primarily concerned with the actual examination of the patient. Doctors do ask questions in this phase, usually questions about specific parts of patients' bodies or specific conditions which bear on the presenting complaints. Nineteen percent of the total number of accounts occurred in this phase. Doctors accepted seven of these accounts (35 percent). They still did not respond to one-half of them (ten accounts) and they openly rejected three (15 percent).

In the closing phase of the interview doctors are typically concerned with summarizing their findings and making treatment decisions. Patients typically have less to say in this phase than in the others. Only 11.4 percent (twelve) of all accounts occurred in this phase. Doctors accepted three accounts (25 percent), openly rejected four (33.3 percent) and did not respond to five (41.7 percent).

By examining the distribution of accounts and responses to accounts across the phases of the medical interview, we once again see manifestations of doctors' institutional authority. The low percentage of acceptances and high percentage of non-responses in the opening and medical history phases suggests that although patients are providing much information, doctors may be [emphasis on may] selectively attending that information. This pattern speaks to doctors' authority to establish and control relevance in medical interviews. The same conclusion holds true for the closing phase. It seems that doctors are not particularly interested in patients' accounts. After all, they typically control the floor in order to explain their diagnoses and make treatment decisions and prescriptions. In the closing phase doctors either rejected or did not respond to three times the number of accounts they accepted (nine to three).

Accounting Practices of Male and Female Patients

The preceding analysis has highlighted some of the accounting practices which are part of the social construction of medical interviews between doctors and male patients. The significance of these patterns is increased by comparing them to some of the patterns documented in medical interviews between doctors and female patients.¹⁰ One question that we may begin to answer concerns the

¹⁰The reader is urged to accept these comparisons of data from interviews with male and female patients with caution. Though the

types of accounts patients offer their doctors. Groce and Fisher (1984) and Fisher and Groce (1986) have studied the accounting practices between doctors and female patients. They report that female patients offer justifications and excuses with about the same frequency (51.6 percent justifications, 48.4 percent excuses). The data suggest that male patients are almost three times more likely to account with justifications (77.1 percent) as with excuses (22.9 percent). While what we see could be exclusively a sex difference in the way women and men talk, evidence suggests a more complex explanation. Mills and Scott and Lyman hinted at the effect of social status on the giving of accounts. Lynxwiler and Groce (1981) partially demonstrated this pattern when they reported that officials from large, corporate coal companies accounted for their companies' deviance with justifications while officials from small companies (usually family-owned and operated businesses) primarily used excuses. It is no secret that men in our society occupy generally higher statuses than women. Thus, it is not surprising that men

samples were drawn and the studies were conducted in the same setting, there was a four-year interval between the studies on female and male patients. The medical interviews were also conducted by two separate groups of second- and third-year residents. The studies also differ in terms of patients presenting complaints. Presenting complaints among men were random--everything from stiff shoulders to constipation to venereal disease. The data gathered on women were the result of more purposive sampling. Women were included only if their presenting complaints indicated the need for pap smears and/or pelvic examinations. Thus, conclusion reached by comparing results from these studies are tentative. They are valuable because they may suggest status differences in the social construction of medical interviews and because they do suggest avenues for future research.

would account to their doctors with justifications while women would account with excuses. In terms of identity maintenance, the higher a person's status, the more that person has to lose. In this context, evidence suggests that justifications, which legitimate rather than excuse, are seen as the most effective accounting strategy, be it for coal company officials or patients in examining rooms.

We may also examine the frequency with which patients give accounts as part of the social construction of medical interviews. Earlier in the chapter I indicated that the forty-three interviews between doctors and male patients yielded a total of 105 patients' accounts. The available information on female patients suggests that they account with only slightly less frequency than men. Groce and Fisher (1984) also worked with a sample of forty-three interviews. They report that the female patients produced ninety-three accounts. While status differences apparently affect what kinds of accounts patients give, they do not appear to affect the frequency with which patients give accounts.

Patients' status appears to affect doctors' accounting practices during medical interviews. Fisher and Groce (1986) report that in forty-three interviews with female patients, doctors accounted to these patients only seventeen times. The data on male patients reveals fifty doctors' accounts (over three times as many as with women patients). One might conclude that the doctors interviewing women simply committed fewer accountable deviations than the doctors interviewing men. The evidence suggests another conclusion. The

interviews with female patients display virtually the same accountable deviations as those with male patients; for example, keeping patients waiting for long periods of time, uncertainty about medications and diagnoses, etc. But yet we find a noticeable absence of accounts to female patients where, based on our understanding of norms, accounts should be forthcoming. I suggest that what we see is once again the relative status difference between male and female patients. The evidence indicates that doctors give accounts more readily when they interact with patients whose status is closer to their own.

Doctors appear to respond to male and female patients' accounts in similar fashion. Groce and Fisher (1984) report that doctors accepted 20.5 percent of their female patients' accounts, they openly rejected 13.7 percent of them and they did not respond to 65.8 percent of all accounts offered. As discussed earlier, when interacting with men, doctors accepted their accounts in only 23.8 percent of the cases. They openly rejected 6.7 percent and did not respond to 70.5 percent of their patients' accounts. While doctors' acceptance and non-response rates are roughly similar for both male and female patients, there is a difference in the rejection category. Comparison indicates that doctors are about twice as likely to openly reject a female patient's account as a male patient's account. This would suggest that as the difference between interactants' status levels decreases, the likelihood of open rejection of accounts also decreases.

We may also compare patients' medical and social accounts. Male patients volunteer accounts more often than female patients.

They also tend to volunteer medical accounts, whereas female patients tend to volunteer social accounts. This finding, when coupled with the conclusion that doctors tend to openly reject female patients' accounts more often than male patients' accounts highlights an interesting pattern. As I have indicated elsewhere, doctors control the definition of "relevant" information during medical encounters. If women tend to volunteer social information where medical information would seem to be relevant (from the doctor's point of view), then it is not surprising that women have such a large number of their accounts rejected.

Also of note is the frequency with which doctors call upon their patients to account for their behavior. In my data, doctors requested only twenty-four (21.9 percent) accounts. Groce and Fisher (1984) indicate that 36.8 percent of all female patients' accounts were requested by their doctors. This would suggest that since male patients are closer in status to doctors than female patients, doctors are more willing to accept men's accounts of their behavior while they are more apt to challenge women's accounts.

The preceding comparisons allow us to at least begin to understand what difference a patient's status makes on the social construction of medical interviews. The central difference would appear to be the amount of institutional authority doctors manifest and the amount of social control they exert during medical interviews. While doctors certainly do make manifest their institutional authority with both male and female patients, for instance, using the appeal

to informed person accounts and not responding to majority of patients' accounts, it would seem that they exercise more social control when interacting with female patients. Doctors clearly reject female patients' accounts more often than male patients' accounts. They also account to women less frequently than they do to men. While they retain the right to decide what topics are relevant during the interview, doctors appear much more likely to lapse into social rather than medical discussions with men than with women.¹¹

Conclusion

The close examination of the actual discourse which doctors and patients produce during medical interviews has enabled us to expand our understanding of accounts and their role in the social construction of reality. The analysis has gone beyond the traditional sociological treatment of accounts which analyzed accounts as if social actors produced them in a contextual vacuum. The analysis displayed accounts as interactional productions which are influenced by both the statuses of the interactants and the organization of the social situation. Thus, doctors' and patients' accounting practices and their responses to the others' accounts are shaped

¹¹Doctors in my data showed a strong tendency to engage in discussions on topics ranging from sports teams to community events to national security and the economy with their male patients. Such discussions are noticeably absent from interviews between doctors and female patients (Fisher and Groce, 1985).

by the nature of the doctor-patient relationship which is, in turn, at least in part, shaped by the medical setting.

Accounting practices and responses to accounts take on increased significance when considered in the context of the medical relationship. Navarro (1976) has argued that the social and political factors woven into the fabric of society are mirrored in the shape of the health care system. In this system class and gender interplay to give predominantly white, male physicians top positions in the medical hierarchy. The issue of control by a predominantly white, male, upper middle-class professional group carries over to the doctor-patient relationship.

The analysis has displayed the asymmetry of the doctor-patient relationship and the authority of the doctor to act as an agent of social control in a number of ways. First, consider that patients volunteered both medical and social accounts. Many of the social accounts were not directly related to the topic on the floor. Doctors appeared to treat these accounts, at best, as if of marginal relevance. There are two ways to interpret these volunteered accounts. On one hand, we could see patients as interactional incompetents who are mixing "apples and oranges," so to speak. On the other hand, a more plausible explanation is that patients are doing interactional work with their accounting practices. Given that doctors direct the flow of interaction, patients have little chance for information input, except to respond to doctors' questions. Since, as Scott and Lyman (1981) have suggested, accounts represent the underlying

negotiation of social identities and since patients have little opportunity to take the floor and insert information into the medical dialogue, the account looms as one of the few ways patients have to try to overcome the asymmetry structured into the situation and contribute to the socially constructed reality of which they are a part.

We also have seen that by focusing on the interactional process of medical interviews, we can identify doctors' responses to patients' accounts as strategies of social control. The doctor is an agent of social control, not so much in Parsons' (1954) sense of bringing deviant (sick) actors back into conformity (health), but in a more interactional sense. The social control strategies to accept, reject or not respond to patients' accounts, enable doctors to dominate the interaction, control the flow of information and, hence, to structure the medical interview itself. The exercise of social control was particularly evident in doctors' responses to patients' volunteered accounts. If we view volunteered accounts as patients' attempts to take control of the floor and/or attempts to provide additional information, the fact that the data reveal that 79.3 percent of all volunteered accounts were either rejected or not responded to is not surprising.

The different types of accounts which doctors and patients give, the different responses they have and the different ways in which they insert accounts into the interaction all inform us about the process of socially constructing medical interviews and the

hidden norms which inform behavior in this and other settings. While medical interviews are interactions between individuals, the interactants are not equal interactional partners. Doctors have institutional authority which patients lack. This authority allows them to act as gatekeepers--agents of social control who dominate the medical process. Patients' own discourse behavior displays their acknowledgment and understanding of this authority. Thus, medical interviews become both social and micropolitical, standing as excellent examples of the social construction of reality. The interactions reflect and sustain cultural, structural and institutional factors and are, in turn, shaped by them.

CHAPTER IV

THE NEGOTIATION OF CULTURAL ASSUMPTIONS ABOUT PATIENTS AS MEN

"I never met a man I didn't like"
--Will Rogers

Introduction

The medical sociological literature is replete with discussions about how doctors actually go about making medical decisions (Cutler, 1979; Wortman et al., 1972; Vu, 1979). We may identify two general orientations to explaining medical decision-making. The first, consisting of a logic-based model, is usually proposed by medical personnel. In this model, it is assumed that doctors simply process available objective information on patients' conditions and reach "logical" diagnoses and treatment decisions. They engage in "differential diagnosis"--meaning they ask patients a series of questions on a wide range of medical possibilities. They gradually rule out certain of these possibilities until they feel they have reached the logical diagnosis, whereupon they make the appropriate treatment decision.

Social scientists represent the second orientation toward explaining medical decision-making. Their focus is on the social (as opposed to strictly medical) considerations which may affect the decision-making process. Najman et al. (1982, 1981) have observed that "An increasing body of evidence is emerging which suggests

that clinical judgements are influenced by factors other than the patient's symptoms and objective physical signs." One of the most important of these "factors" is the evaluative perception of patients formulated by doctors during medical encounters. Doctors' evaluative perceptions of patients are variously known in the literature as "stereotypes" (Najam et al., 1982), "categorizations" (Gordon, 1983), "classifications" (Papper, 1972), "evaluations" (Roth, 1979), "reactions to behavior" (Lorber, 1975), and "cultural assumptions" (Fisher and Groce, 1985). Regardless of the terminology employed, the conclusions these researchers reach are the same: doctors construct either positive or negative evaluations of their patients which influence the social construction of medical interviews and, hence, the delivery of health care.

Lorber (1975) argues that doctors typify their clientele as either "good" or "problem" patients (see also Kotarba and Seidel, 1984). She finds that doctors evaluate patients as "good" when they do not make trouble for the hospital staff and do not interrupt established medical routines. Patients who violate these norms of the medical relationship are considered "problem" patients. Biener (1983) suggests that factors such as the social distance between doctors and patients, the seriousness of patients' presenting complaints and the perceived level of patients' cooperation influence doctors' perceptions and evaluations. Hauser (1981) adds that social class differences between doctors and patients strongly influence doctors' differential evaluations of patients (see also Papper,

1972). Finally, Barr (1983) suggests that the perceived seriousness of patients' presenting complaints is the strongest predictor of doctors' responses to their patients.

The aforementioned studies (and others like them) locate doctors' evaluations of patients within the normative framework of the doctor-patient relationship and the medical encounter itself. These studies suggest that "patient" is the master status operating when a person visits the doctor. Also, Macintyre (1977) has discussed doctors' categorizations of patients, but has located the source of doctors' categorizations outside the framework of the doctor-patient relationship. She argues that during the course of consultations concerning unwanted pregnancies, doctors typify their clients as "good" or "bad" women rather than "good" or "bad" patients. Doctors ferret from the culturally produced collage of norms governing gender role behavior, sexuality and family interactions information which allows them to categorize their patients as "good" or "bad" women. Fisher and Groce (1985), following Macintyre, have reported that woman emerges as the master status and overrides the status of patient in the negotiation of cultural assumptions during initial medical interviews between doctors and patients (see also Roth, 1979).

Whether the master status is patient or woman, studies (with the exception of Fisher and Groce, 1985) all take the process of stereotyping or the negotiation of categorizations as unproblematic. While Fisher and Groce have analyzed the process through which doctors identify patients as either good or bad women and how this evaluation,

once formed, structures discourse between doctors and patients and influences the delivery of health care, we have no comparable data on the interactions between doctors and male patients. The purpose of this chapter, then, is to provide a descriptive analysis of the negotiation of cultural assumptions, or norms, between doctors and male patients. The analysis will focus on how doctors' knowledge and use of cultural assumptions concerning the nature of men in our society influences the medical interviews, treatment decisions and, hence, the social construction of reality. The results will be compared to available information on cultural assumptions about female patients.

Displaying Cultural Assumptions

The discourse in twenty-three (53.5 percent) of the forty-three medical interviews displayed the negotiation of cultural assumptions. The predominant tendency was for doctors to use cultural assumptions about men qua men to evaluate and categorize their clients (87 percent of the transcripts which contained cultural assumptions). Doctors displayed a pattern of making cultural assumptions about the three primary dimensions of male patients' social socioeconomic status-- occupation, education and income. The following excerpts illustrate cultural assumptions about men and their occupations:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: well uh I think you are probably going to find that if you go back doing what you did you're gonna reinjure it you know so//what you pretty much need to do is take it easy for uh I'll give some medicine that'll help decrease the inflammation for say a week or so okay	P: okay	P: //uhhuh
D: and if you're no better in a week then just come back and see me alright uh your lungs sound clear your shoulder seems to work okay and I probably what it is just a muscle back there alright so uh I'll get you that and you can you need an excuse to you know that you were in here to see the doctor and//	P: //I work for myself so//	D: //oh do you okay
P: I just hadn't hurt myself in so long that I figured I best at least have it looked at		

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: yeah uh alright is this somebody you're living with now	P: uhhuh	D: okay
D: okay what sort of work do you do	P: I don't I just ride horses I was working at a restaurant for my family but I decided you know to take the summer off//and some training showing horses	D: //uhhuh

(#10, p. 3)

The patient in the first example is a muscular, solid (6'1", 201 lbs.) man. His presenting complaint is shoulder pain which he incurred while running a drill at work. After making the diagnosis of a muscle pull, the doctor explains in detail why the patient will need to rest his shoulder for a week or so. The doctor ends his discussion by asking the patient if he needs a "doctor's excuse." With that question the doctor displays an apparent cultural assumption concerning men in our society who do heavy construction work--they work for someone else's company. Hence the doctor's reasoning for asking the patient if he needed an excuse. The patient's response promptly invalidates the doctor's cultural assumption: "I work for myself, so" The patient does not even have the opportunity to complete his response before the doctor interrupts to interject a surprised "Oh, you do?" which signals the incongruence between the doctor's evaluation and the factual information concerning the patient's occupation.

In the second example, the patient presents with a burning sensation in his penis. Prior to the excerpt included here, the doctor asked the patient a series of questions about his sexual behavior, particularly the number of recent sexual partners. The patient explained that he had only one recent sexual partner. The doctor then discovers that the patient lives with his current partner. The information gathered by the doctor apparently allows him to construct a picture of the patient as a fairly "typical" man. This may explain the doctor's next question: "Okay, what sort of work do you do?" This question seemingly relies on the cultural assumption that "typical" men in our society work for a living. As in the first example, the patient's response invalidates the cultural assumption and establishes the patient as a somewhat atypical man. He explains to the doctor that he quit his job to take the summer off and train horses. Overall, in 20.6 percent of the cases where doctors displayed cultural assumptions about patients as men they made references to norms concerning men patients' occupations.

A less prevalent but still interesting cultural assumption used by doctors focuses on the educational level/intelligence of their male patients. Cultural assumptions about patients' educational level comprised 8.8 percent of the total number of cultural assumptions. The following two examples, one of which suggests that the doctor assumes the patient to have a high level of education (#5, p. 4) and the other, which suggests that the doctor questions the patient's intelligence (#37, p. 9), illustrate this form of cultural assumption:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: any physical problems at all any trouble with certain joints uh muscles weakness anywhere	P: no	
D: I I tend to cut this shorter an educated person like you I don't have to go through and ask every little// thing uh are you on a regular fitness program of any kind	P: no	P: //uhhuh
(#5, p. 4)		
D: cover up can you see out of that left eye	P: yeah I can see out of eye pretty good	
D: cover up your left eye first let's see your right one can you read uh read that line read those numbers	P: yeah	
D: go ahead and read them	P: 4//2 8 6 6 5	D: //uhhuh
(#37, p. 9)		

The patient in the first example is a white, twenty-nine year old assistant professor at a large state university. He has come to the clinic for a complete physical examination which will allow him to be re-certified as a scuba diver. The two interactants have barely begun the medical history phase of the interview when the doctor makes a blatant cultural assumption concerning the patient's educational level: "I tend to cut this shorter, educated person like you I don't have to go through and ask every little thing."

The assumption here is that since the patient is a college professor, he is obviously educated and as "all doctors know," educated patients are easy to deal with because they can clearly articulate their medical histories.¹ The curious thing about this doctor's cultural assumption is that it leads him to conduct a far less than thorough history-taking. This is noteworthy because it violates one of the standard rules of operation at the clinic. Doctors are trained to take full medical histories on all patients who come to the clinic for the first time. The data produced by the history-taking are put on file so that should the patient return to the clinic for another problem, the attending physician will have potentially vital information at his/her immediate disposal.

The cultural assumption operating in the second example is almost the opposite of the first example. Here, the doctor and patient are in the physical examination phase of the medical interview. The doctor is about to get the patient to read an eye chart. The way the doctor begins the sequence is particularly interesting. He says: "Can you read uh read that line, read those numbers?" Possibly, the doctor merely momentarily lost his train of thought. That might explain the pause and subsequent "uh" before he continued. I think, however, that this example warrants a very different

¹This finding is strongly supported by field notes gathered in the research setting. On numerous occasions doctors told me informally how they detested "stupid" patients and relished "smart" patients because the latter simplified doctors' jobs.

interpretation. Consider the following information: the patient is a forty-three-year-old black man who has worked construction-related jobs all of his life; during the medical history portion of the interview, the doctor asked the patient to "stress his mind" and try to recall what he had eaten the day before; similar behavior was never evidenced during interactions between doctors and white patients; and, the doctor's "Uh, read that line, read those numbers," was uttered very quickly, almost embarrassingly, as if the doctor realized the inappropriateness of his own utterance ("Can you read?"). I suggest that the doctor's highly atypical utterance displays his reference to a common cultural assumption, namely, that many black men in our society, particularly unskilled laborers, cannot read.

Another type of cultural assumption displayed in the data makes reference to patients' income levels.² The following excerpt illustrates the characteristic form of this type of cultural assumption.

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: uh we've got two choices to go with uh one is the uh once a day medicine that is relatively expensive cost you about a dollar a day . . .	P: I don't care for the price I want to get well	

²I found evidence of four other types of cultural assumptions in the data. These were assumptions concerning patients' race, sexual behaviors, mental health and family lives. However, the

- D: well//uh if that's the case I want to caution you going to have to be treated for at least 6 weeks
 P: that will be fine D: okay
- D: six weeks at a dollar a day is about 42 dollars
 P: yes D: okay
- D: can you go that high P: yeah high enough to be well D: alright
- D: uh I'll go ahead and put you on that medication then alright
 P: alright I do want to get well be a well man again

(#21, pp. 6-7)

In this example the doctor's cultural assumption concerning the patient's income is displayed in the discourse. The patient here is a seventy-two-year-old black man whose presenting complaint has been diagnosed as proctitis. The doctor apparently assumes that the patient is incapable of paying for the medication necessary for his recovery. He begins the discussion by explaining to the patient that the medication is "relatively expensive." The patient subsequently tells the doctor in so many words that price is no object. Still not satisfied (and apparently still operating on the cultural assumption that an elderly black man cannot afford expensive medication), the doctor attempts to change the patient's

frequency of occurrence of these assumptions in the data do not suggest a pattern and, hence, are excluded from this part of the analysis.

mind three more times. Finally the patient convinces the doctor that he can afford the medication, emphasizing that he wants to "be a well man again," and the doctor prescribes the medication.

The data reveal that the most prevalent cultural assumptions made by doctors concerned patients' use/abuse of drugs. These assumptions made reference to alcohol, marijuana and prescription drugs. The discourse displayed cultural assumptions about men and drug use in 32.3 percent of the cases. The characteristic form of these cultural assumptions is illustrated in the following examples:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: are you a smoker do you smoke cigarettes	P: nuhhuh	
D: do you drink much liquor	P: yeah I drink liquor every now and then//not heavy	D: //every now and then
(#14, p. 3)		
D: okay and uh I need to know about your social history do you smoke	P: I do	
D: how many packs	P: uh the only time I smoke cigarettes is a pack a day generally I smoke a pipe so I can say it's equal if I don't smoke cigarettes I smoke pipe about the same	
D: how long have you been smoking	P: 16 years 16 or 17	

- D: do you drink very
much alcohol P: not very much
occasionally D: occasionally
- D: what do you
usually drink? P: well depending on
the [unintelligible]
I drink liquor if I
drink liquor a few
shots a night I mean
for example uh after
2 weeks I drink just
a few shots of liquor
or half a bottle of
wine
- D: but it's not very
frequent P: no no sometime I
don't I don't
drink for a month
sometime I drink
every other week D: okay

(#27, p. 6)

The doctor and patient in the first example are interacting during the medical history phase of the interview. The function of this phase is to allow the doctor to gather both medical and social information which may be relevant to the patient's presenting complaint or which may be referred to if the patient returns to the clinic for some other medical problem. Notice the difference between the doctor's questions about cigarette and alcohol use. The question about cigarettes is neutral--it presumes nothing about the patient's tobacco use habits. The second question is not neutral. It presumes that the patient uses alcohol and seeks to quantify the amount. The phrasing of the question is highly atypical (Fisher and Groce, 1985). This clinic is located in a conservative Bible belt area where many people do not drink and some would even be offended if

asked about drinking. Thus, it is most unusual to hear questions phrased in ways which presume the patient's use of alcohol. The more typical question is, "Do you drink alcohol?" If the patient answers affirmatively, the doctor usually follows with a more specific question--"How much alcohol do you drink?" The doctor in this example appears to be using a cultural assumption about men in our society, namely, that they drink alcohol.

The second example is similar to the first. Again the doctor's question presumes that the patient drinks: "Do you drink very much alcohol?" After the patient validates the doctor's assumption, doctor and patient again engage in a discussion about the amount and frequency of the patient's alcohol consumption. After the patient's second explanation, the doctor is apparently satisfied. The extended discussions in these examples as well as others in the data suggest the presence of strong cultural assumptions concerning men's patterns of alcohol consumption.³

In only 10.8 percent of the cases in which doctors made cultural assumptions, did they make assumptions about men as patients. One case centered around the doctor's assumption that the patient's pain threshold was not as high as a "typical" man patient's should

³This finding is especially interesting when compared to the data on interactions between doctors and female patients analyzed by Fisher and Groce (1985). They report very few extended discussions about alcohol use among female patients, thus suggesting the operation of a radically different cultural assumption.

be. The two others focused on doctors' assumptions that their patients were incapable of following prescribed medical regimens. The final case, which will be discussed at some length, displays the doctor's evaluation of the patient and his presenting complaint as not serious enough to warrant the doctor's time:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: okay well let's pull off your shoes since that's what you came for we've sat here and///gabbbed the day away	P: well I know it// I've wasted your time	P: //(laughs) D: //well D: (laughs) well I've got it to waste today
P: well uh you like want me to take both of them off	D: yeah	

(#30, p. 12)

The patient is a fifty-nine-year-old man who complains of a burning sensation in his feet and toes. He is unusually talkative and as a result the medical interview has proceeded at a snail's pace. The excerpt which marks the beginning of the medical history phase begins on transcript page 12. In a more typical interview, the doctor has initiated the medical history phase by page 2 or 3. The doctor has attempted to redirect the interaction on several previous occasions. Finally he tells the patient to take off his shoes since that is the reason he came to the clinic. Notice the addition to the doctor's statement: "We've sat here and gabbed

the day away." The patient, apparently realizing his deviation from the norms regarding typical patient behavior, attempts an apology of sorts: "Well, I know it. I've wasted your time." The doctor next makes a curious comment: "Well, I've got it to waste today." The comment seems to display the doctor's evaluation of this man as a patient who is indeed wasting the doctor's time. In the end, the doctor finally diagnoses the patient's problem as arteriosclerosis. He tells the patient to wait in the examining room until he returns. We (staff and myself) found the patient still sitting in the examining room an hour later, the doctor long gone for the day.

The Negotiation of Cultural Assumptions

The negotiation of cultural assumptions was a pervasive pattern which occurred in the majority of transcripts in the data set. There were instances, particularly in very brief medical interviews, where negotiations were not evident. Overall, twenty-three of the forty-three medical interviews displayed the negotiation of cultural assumptions. The twenty-three interviews yielded a total of thirty-seven cultural assumptions, thirty-three of which were assumptions about the behavior of men in general and four of which were assumptions about the behavior of men as patients. These norms about patients as men and men as patients emerged and were negotiated against a full backdrop of cultural expectations. In these instances, doctors' behaviors seemed to indicate that they "liked" or

"disliked" their clients as either men or patients.

Since the predominant pattern in the data was for doctors to use cultural assumptions about patients as men, I have chosen two interviews, both conducted by the same doctor, to analyze in depth.⁴ These two interviews represent extreme, almost polar opposite cases. The first case is an outside referral while the second is self-referred; the first case represents a chronic presenting complaint while the second is much less serious; in the first case the doctor clearly discovers the need for repeated contact with the patient while the second case is a onetime interaction.

In the first interview the doctor relies on cultural assumptions about men in our society to reach a negative evaluation of his patient; in the second interview he reaches a positive evaluation. The purpose of the comparison is to display the intricacies of the reflexive relationship between cultural assumption and the communicational work interactants do to sustain them. A detailed analysis of these two cases not only reveals different sets of cultural assumptions, but also displays how cultural assumptions emerge, structure the discourse between doctors and patients and influence the delivery of health care.

In each case, I investigate how doctors and patients negotiate cultural assumptions over the course of the medical interview and comment on the relationship between these assumptions and the delivery

⁴Based on reviews of transcripts and my own observations, this resident's attitudes and behaviors appear to be fairly representative of the resident population.

of health care. The analysis extends beyond the linguistic boundaries of the transcripts to blend linguistic data with ethnographic data. Interactants in the medical setting rarely, if ever, say aloud all that contributes to the interview process. Patients rarely say aloud that they do not trust their doctors, that they feel unheard and manipulated or that they are dissatisfied with the medical care they have received. Similarly, doctors rarely say aloud that patients look or talk like poor, uneducated men. They do not often say that the ways in which patients talk, dress or act leads them to believe that they are "good" or "bad" men that such evaluations ultimately affect treatment decisions. While such things are rarely said aloud, observations suggest that these and other factors do contribute to the diagnostic/treatment process (Fisher and Groce, 1985).

The first patient is Joe, a muscular, forty-four-year-old, single black man. His presenting complaint is high blood pressure (210/130) which the Red Cross discovered during a routine check of laborers at a local construction site. As the interview progresses, Joe displays an inability to communicate clearly with the doctor and a lack of understanding about the functioning of his own system:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: what's going on with you today	P: well I well I work yesterday//and the Red Cross came down on the job they checked all the working//people and I well I wasn't hurting I was feeling good and	D: //uhhuh D: //uhhuh

they said mine
was 210

D: your your//

P: //blood was 210
yesterday

D: what was 210

P: my high//

D: //your blood pressure

P: yeah and then uh I
went to I went to
the health department
and they registered
226

D: that's pretty high

P: yeah

D: have you ever had
that problem before

P: no I didn't know it but
they came down I didn't
know I had no blood
pressure

D: when was the uh last
time you'd had your
blood pressure checked
before yesterday

P: uh well that's a long
time I didn't know I
had it because when
they came down there
they just came on the
job

D: how old are you

P: forty-four

D: forty-four

D: how often do you get
your blood pressure
checked

P: well that's the
first time I ever
got it checked

D: first time you ever
had it checked

P: yeah

D: you ever been seen
by a doctor

P: uhhuh//I've been
you know I've been
uh to the doctor
before but I didn't
get no blood
pressure

D: //uhhuh

D: they never checked
your blood pressure P: no

D: when was the last
time you was seen by
a doctor P: well when they uh
catheterized me

This lengthy excerpt provides us with three interesting observations. First, the doctor appears to have a difficult time communicating with Joe. The combination of Joe's syntax, grammar and lack of referents make his articulation of his condition difficult for the doctor to understand. Three times the doctor seeks clarification before he finally understands that the problem is Joe's blood pressure. The second observation is that if the doctor is beginning to evaluate Joe and form a picture of him as a person, the information Joe provides about his medical history surely contributes to that picture. When the doctor establishes Joe's age (forty-four), his next question--"How often do you get your blood pressure checked?--displays a cultural assumption that middle-aged men, particularly blacks (who, as a statistical group, have a higher incidence of hypertension than whites), routinely monitor their blood pressure. When Joe reveals that he's never had his blood pressure checked before now, the doctor is incredulous: "First time you ever had it checked?" The final observation to be made here is that the doctor has indeed begun to form an evaluative picture of Joe. This observation is suggested by the doctor's "code-switching" (Bernstein, 1971) in his final initiation: "When was the last time you was seen by a doctor?" (instead of, "When was the last time you were seen by a doctor?")

Since "code switching may provide evidence for the existence of underlying, un verbalized assumptions about social categories" (Gumperz, 1982:99), we may begin to see the doctor's use of cultural assumptions about black men, particularly those relating to education, linguistic competence and health maintenance.⁵

Later in the interview, during the medical history phase, an exchange occurs which suggests that the doctor is relying more heavily on cultural assumptions about black men:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: do you have any allergies to any medications	P: no	
D: do you smoke	P: no I don't smoke neither	
D: have you ever smoked	P: no sir I don't drink neither	
D: you don't drink	P: no	D: okay
D: do you do any street drugs	P: no no drugs neither	D: okay
P: I come from a good family maybe that I got a good Christian mother she she taught me//my sisters and brothers they drink but I don't ever I just don't ever//		D: //taught you right huh D: //good for you

⁵There is empirical evidence for the assertion that code-switching does reflect interspeaker attitudes and assumptions (e.g., Poplack, 1981; Valdes, 1981). The importance of code-switching for sociology should not be underestimated. Gumperz (1982:99) goes so far as to say that studies of code-switching "might bridge the gap

() I've got some
 kind of the only trouble
 I've got () is
 gambling that's my only
 problem I gamble some
 you know.

D: okay anyone in your
 family have high
 blood pressure

In this excerpt the doctor is gathering medical history information on Joe. He asks the standard question about tobacco use, "Do you smoke?" Joe answers, "No, I don't smoke neither." Notice the doctor's next question. He asks Joe, "Have you ever smoked?" This question is atypical and possibly displays a cultural assumption. Joe has just told the doctor that he does not smoke. The doctor, apparently assuming that most black men smoke, does not fully accept Joe's answer. It is as if the doctor, given the present information that Joe does not smoke, assumes that he must have smoked sometime in the past. Joe's answer, however, invalidates the assumption. When Joe explains that he has never smoked, he also adds, "I don't drink, neither." Again, the doctor's reaction to this bit of information displays cultural assumptions. In a form very uncharacteristic of other medical interviews, the doctor challenges Joe by probing in disbelieving tone, "You don't drink?" The doctor's question suggests that it comes as a shock to him that Joe does not drink--perhaps because his question assumes that it is "normal" for men,

between macro- and micro-analyses by providing insights into the broader social concepts in interpersonal relations."

or for black men, to drink. The doctor's next question is even more surprising: "Do you do any street drugs?" Doctors in these data never asked white, middle-class patients if they did "street drugs." Why, then, does the doctor ask the question of Joe? I suggest that the question displays yet another cultural assumption commonly held by white people in our society--that black men probably use illegal or "street" drugs.

Later in the interview the discourse displays more evidence of the negotiation of cultural assumptions:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: what kind of work do you do	P: () you know that school they bring down in uh you know that school that's been way down in _____	D: no I'm not familiar with it
D: you're labor for construction	P: yeah	
D: that what you've done most of your life	P: no I've been a roofer worker all my life//they sold that place _____ Roofing Company and they sold it and I've been on this since December 10 I think that's right I've been on since December 10 so I//	D: //roof work
D: //you've had a pretty steady job though	P: I'd say 1, 2, 3, 4, 5 yeah about 5 days a week//about a	D: //uhhuh

month since I been
out here

D: uhhuh

D: you've been able to
keep a steady job
most of your life

P: yeah I been at _____
27 years//before
they sold it

D: //okay

D: you married

P: single

D: single

P: yeah I got some
kids

D: uhhuh

And later

D: . . . you're pretty
muscular you must get
a lot of exercise on
the job

P: (laughs) no

D: work hard

P: work pretty hard

D: how many hours a day

P: 8 hours sometimes
I work overtime
maybe a half hour
or maybe a hour

D: I'll just feel around
your head here first
you're pretty
disappointed
you're not
working today

P: yeah I I was going
to work but they
wouldn't let me work
()

D: you're not going to
get paid for today

P: no (laughs)

D: that's pretty
important huh

P: no they they way this
is very important

D: this is more
important I think

P: yeah I say that that
lady she said that over
at the health department

This excerpt begins innocently enough with the doctor's routine question about Joe's occupation: "What kind of work do you do?" Joe explains that he is currently doing construction work on a school. The doctor's next question--"You're labor for construction?"--may be interpreted in at least two ways. His question could merely be an attempt to firmly establish what Joe's occupation actually is. After all, the last phrase of Joe's previous response was unintelligible to both the transcriptionist and me; the doctor may not have understood what Joe said, either. Such an interpretation is not particularly likely, though, because the doctor had read Joe's patient information sheet prior to the beginning of the medical interview.⁶ A more plausible interpretation is that the doctor's question contains an evaluation of Joe and thus refers to a cultural assumption about "typical" jobs for black men. This interpretation is at least indirectly validated by the doctor's next three questions. He is unusually persistent in establishing Joe's work history: "That's what you've done most of your life," "You've had a pretty steady job, though," and "You've been able to keep a steady

⁶Patients who come to this clinic for the first time are routinely required to submit medically relevant demographic and social information to staff personnel. The information sheet provides the staff with data on patients' age, height, weight, place of residence, occupation, income, education, marital status and tobacco and alcohol use patterns. The staff gives the information sheets to nurses who then affix the sheets to the examining room doors. Each attending physician then briefly reviews the information just prior to entering the examining room to begin the medical interview.

job most of your life?" In addition to validating the earlier cultural assumption, the last two questions seem to display another of the doctor's cultural assumptions, that lower-class, undereducated black men, when compared to their white counterparts, may have trouble maintaining a steady job. It should also be noted that none of the interviews between doctors and middle-class, educated white patients contained exchanges of this sort.

The last part of the excerpt contains more evidence of cultural assumptions about men and their work. The doctor has begun the physical examination phase of the interview: "I'll just feel around your head here first." Yet he immediately returns to the topic of Joe's occupation: "You're pretty disappointed you're not working today." I have not written the doctor's utterance as a question because his intonation did not indicate a question. The intonation of the remark suggests merely a statement or, more subtly, an evaluation. Joe, however, apparently hears the doctor's remark as a question and replies: "Yeah I I was going to work but they wouldn't let me work." The doctor's next utterance is much like his first, not really a question but more of a statement. "You're not going to get paid for today." Joe again responds as if the doctor had asked a question "No, ha ha ha." Notice Joe's laughter immediately after his response. The laughter could be an example of what Jefferson (1984) has described as laughter during "trouble talk"--laughter which establishes a speaker's "trouble-resistive" orientation and attempts to show that the speaker can make light of a troublesome

situation. Another possible explanation is that Joe's laughter displays his understanding that the doctor has just made a very atypical utterance. Joe obviously knows that he will not get paid for his time spent at the clinic; he may assume that the doctor should know also--hence, Joe's response (laughter) to what essentially is an unnecessary remark by the doctor. The doctor's apparent reasoning for this obtuse sequence becomes clear with his next utterance: "That's pretty important, huh?" I suggest that this entire line of questioning displays more of the doctor's cultural assumptions. It would appear that the doctor assumes that Joe, as an unskilled manual laborer who gets paid by the hour, is probably more interested in getting out of the examining room and getting back to work than he is with getting his high blood pressure problem under control. The final exchange in this excerpt seems to support such a conclusion. Joe follows the doctor's question--"That's pretty important, huh?"--with a response that the doctor apparently did not expect to hear: "No, they say this is very important." The doctor's next utterance displays his inattentiveness to Joe's response: "This is more important, I think." He might have said, "You're right, Joe, this is more important." Instead, he acts as if he either never heard Joe's remark or he heard what he assumed Joe would say: "Yeah, getting back to work is the most important thing."

The middle portion of this excerpt is important because Joe supplies the doctor with information that influences the doctor's evaluation of him. After the initial exchanges, the doctor may

have been building a fairly positive picture of Joe. Joe has explained that he has held a steady job for twenty-seven years. The doctor's next question--"You married?"--may signal an assumption that if a man, particularly a black man, holds a steady job, then it is probably because he is supporting a family. Notice the doctor's reaction to Joe's response. Joe says, "Single." The doctor then repeats "Single?" in a high-pitched voice with a questioning intonation. Unless the doctor is hard of hearing (which he obviously is not based on his behavior in other parts of the medical interview and in interviews with other patients), what was the purpose of his utterance? I suggest that Joe's response took the doctor by surprise because it was inconsistent with the picture of Joe the doctor was building based on the work history information. Joe then further aids the changing picture of him by informing the doctor, "Yeah, I got some kids." The doctor's comment, "Uhhuh," was made in such a way as to suggest that what the doctor was really saying was, "That figures"--thus validating another commonly held cultural assumption about black men, i.e., that black men father children without the social legitimation that marriage provides.

From the moment the doctor encountered Joe in the examining room, through the discussions of education, employment, and drug use, we are left with the distinct impression that the doctor does not particularly like Joe. Whether based on cultural assumptions about black men, or cultural assumptions about patients' educational

levels,⁷ or a combination of both, the conclusion that the doctor has negatively evaluated Joe seems warranted. The next important step is to document what effect, if any, the doctor's negative evaluation of Joe has on the delivery of health care. Remember that Joe's presenting complaint, his reason for coming to the clinic, is his unusually high blood pressure. There are, however, some other interesting bits of information regarding Joe's overall medical condition which emerge as the medical interview unfolds:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: when was the last time you was seen by a doctor	P: well when they catheterized me	
D: catheterized your//	P: //yeah	
D: what did they catheterize you for	P: well I was hurting one time been about 2 or 3 months I was just hurting	
D: hurting where	P: right down in there (points to groin area)	
D: they catheterized your bladder	P: yeah they took all the water from the bladder	
D: they took your water off your bladder	P: yeah	

⁷Based on a multivariate analysis, Waitzkin (1985) has concluded that a patient's educational background is one of the strongest predictors in doctors' evaluations of patients, the amount of information transmitted to patients and the quality of care the patient receives.

D: where did you have
your catheterization
done P: _____ hospital

D: _____ hospital P: yeah

D: in the emergency
room P: yeah

D: did they check your
blood pressure in the
emergency room P: no

The most interesting aspect of the doctor's behavior in this sequence is his ignoring of potentially important medical information. This is Joe's initial visit to the clinic. As I have explained earlier, residents are taught to gather complete medical histories on all first-time patients. This doctor, however, fails to follow through with the information-gathering process. He does establish that Joe's bladder was catheterized at a local hospital. More important, though, are the facts he fails to establish: (1) the actual reason for the catheterization--the only information Joe provides is that he "was hurting," and (2) when the catheterization was actually performed (Joe says, "About two or three months ago"). After this brief and incomplete exchange, notice how the doctor re-directs the discourse back to Joe's blood pressure problem: "In the emergency room?" This excerpt begins to display a pattern, well-documented by Fisher and Groce (1985). They found that doctors were hesitant to discuss issues other than presenting complaints with female patients they evaluated negatively or "disliked."

Later in the interview, Joe provides the doctor with more medical information which is ultimately unattended:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: you have never been in the hospital	P: no about yeah I say about 6 about 6 it's been 6 or 7 years ago I was over at _____ hospital and I I threw up a whole tub of blood// yeah oh tha tha they had tubes in mouth ear nose down in here that's that's//	D: //uhhuh
D: //and you were there overnight	P: yeah been there about 7 or 8 years ago	D: 7 or 8 years ago
D: what was wrong then	P: this I don't know I had gone to work up on the roof that day I just throw a lot of blood	
D: you were on the roof working did they find out what was wrong why you were throwing up that much blood	P: no they they//	
D: //was it bright red blood	P: it was red blood it was in a bathtub you know it was 7 or 8 years ago I don't know	
D: well anyway you haven't been aware of any blood pressure problems either 6 or 7 years ago	P: no	

In this excerpt, the doctor is trying to establish whether or not Joe has ever spent the night in a hospital. Joe responds initially

by saying "No," but then changes his answer to "Yeah" and tells the doctor about going to the hospital because he was throwing up blood. The doctor appears to have a difficult time establishing the reason for Joe "throwing up a tub of blood." After a couple of unsuccessful tries the doctor drops the subject and again returns to Joe's presenting complaint: "Well, anyway, you haven't been aware of any blood pressure problems either six or seven years ago." In fact, not only does the doctor fail to pursue the blood vomiting problem, he does so far as to ask Joe: "Okay, you have any, uh, problems that you are aware of with your health?"--implying that Joe's episode of throwing up a tub full of blood does not count as a medical problem!

Immediately after the discussion of Joe's throwing up blood, even more important information comes to light:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: well so so you haven't had any problems since then	P: no sir	
D: did you have any problems before you threw up the blood	P: no sir I know I I had an ulcer but then//but it wasn't nervous just stuff I couldn't eat or couldn't look at you know just make me sick	D: //you had an ulcer
D: was that 6 or 7 years ago or even before	P: well I have that now still I can't I can't you know	

look at it just makes
me sick I can't eat
all of that stuff I
don't know what it is
so yeah

D: okay are you on any
medications right
now

P: huh

D: are you on any
medications right now P: no

D: okay

D: do you have any
allergies to any
medications

P: no

Here, Joe provides the doctor with information about his ulcer.

Again the doctor fails to gather much additional information about the existence or condition of the ulcer. He merely attempts to establish a connection between the ulcer and Joe's throwing up blood: "Was that six or seven years ago [roughly the time Joe said he threw up the blood] or even before?" Joe then provides the doctor with potentially important information--he still has the ulcer. Rather than following up this information with questions pertinent to the topic, the doctor instead switches topics and continues with basic medical history questions: "Are you on medications right now?" and "Do you have any allergies to any medications?"

Near the end of the interview, during the physical examination phase, Joe provides the doctor with yet another piece of important information. Doctor and patient are discussing Joe's circulation and the doctor wonders if Joe has ever had the pulses in his groin checked:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: did they take a listen to these pulses down here (points to Joe's groin)	P: well yeah I I think they took that about the time I had intercourse with a woman	
D: what's that	P: I hurt right in there sometimes after intercourse	
D: one time you do	P: well most of the time I don't know I guess if I get too much I start hurting	
D: you hurt in there right now	P: no	
D: when was it you were hurting a long time ago or just recently	P: it's been recent	D: uhhuh
D: have you ever had venereal disease infection	P: well this girl turned my name in that I told her there ain't nothing wrong with me so they took over the health department and they give me some 9 pills to take and uh well they told me to call back well I didn't ever call back 'cause that girl she said she ain't had none and the nurse said () I don't know I don't know why she turned my name in	

D: when was that P: it ain't been too
long ago about a
month ago

D: about a month ago P: yeah

.
.
.

D: when was it that you
were hurting down
there P: well I was
hurting could be
yesterday//it D: //could be
didn't hurt all yesterday
that much

D: do you have any
discharge from your
penis P: well sometimes well
uh when I shoot off
I reckon it starts
hurting

D: when you shoot off
it hurts P: sometimes and
sometimes we have
done 2 or 3 you know

D: okay well maybe I'd
better check you out
here might ought to
while we're checking
about your blood
pressure//cause you
might have gonorrhea P: (laughs) I ain't
got no gonorrhea// D: //we hope
nope (laughs) I not
know I ain't got
no gonorrhea

D: well let me check you
out just to make sure
have a seat uh take a
look at this and we
need to talk to you
your main problem is
your blood pressure P: yeah D: okay

D: I'm concerned if you
hurt down there which
shouldn't happen when
you ejaculate//when
you shoot your wad it
shouldn't hurt P: //yeah

 P: huh

D: it should not hurt P: should not hurt D: no

D: so I'm concerned
about there may be
something wrong
there but your main
problem is your
blood pressure P: yeah

There are a number of important facets to this excerpt. The doctor begins the sequence by asking Joe if anyone has ever taken the pulses in his groin. Joe replies that these pulses were checked "about the time I had intercourse with a woman." The doctor requests clarification and Joe goes on to explain: "I hurt right in there sometimes after intercourse." After a few more exchanges, the doctor asks a curious question: "Have you ever had venereal disease infection?" There are at least two medical diagnoses of Joe's problem, pain after intercourse. The doctor immediately tries to establish one of these explanations--Joe has had venereal disease. There is, however, another equally plausible explanation. Considering Joe's age (forty-four), his symptoms could indicate trouble with his prostate gland--a condition which has no necessary relation to venereal disease.⁸ Why does the doctor never mention the prostate gland

⁸This bit of medical information was gathered during my informal conversations with residents and staff physicians at the clinic. Pain in the lower pelvic area after ejaculation is one of the classic symptoms of prostatitis. Residents are taught to routinely check prostate glands of patients over forty years of age.

and why does he not perform a prostate exam when one is clearly warranted? Perhaps because the doctor is once again reacting to a cultural assumption about black men, that they are likely to be the victims of sexually transmitted diseases. This would seem to be the case, especially when Joe explains that a "girl turned my name in [to the Health Department]." The curious part of this exchange is how the doctor persistently pursues the "VD talk." He does so even though Joe provides additional information that invalidates the assumption of gonorrhea. The doctor finally declares that he ought to check Joe as long as he is checking about the high blood pressure (return to presenting complaint once again) because Joe "might have gonorrhea."

Notice, too, that the doctor once again code-switches. Toward the end of this exchange, the doctor explains: "I'm concerned if you hurt down there which shouldn't happen when you ejaculate." The doctor has used the proper medical term, "ejaculate." Joe displays his understanding of what the doctor has just said: "Yeah." The doctor then code-switches and recycles the information: "When you shoot your wad, it shouldn't hurt." This is interesting given that Joe had already indicated that he understood what "ejaculate" meant and that it was Joe who had twice previously used the term "intercourse" rather than one of its many less scientific equivalents.

Finally, we see once again the pattern described earlier. The doctor seems steadfastly dedicated to always returning to Joe's presenting complaint, his high blood pressure. After the lengthy

discussion concerning Joe's problem of pain on ejaculation, the doctor says: "We need to talk to you. Your main problem is your high blood pressure." Again, near the end of this excerpt, the doctor concludes: "So I'm concerned about, there may be something wrong there, too, but your main problem is your blood pressure." One has to wonder how this must sound to Joe. Every time he has sexual intercourse, he hurts--yet the doctor keeps emphasizing that his "main problem" is a condition which, in its early stages, has virtually no physical symptoms.

We are now in a position to see how cultural assumptions about men patients may influence the delivery of health care. The discourse has displayed numerous assumptions by the doctor about men, blacks and black men in particular. The doctor made assumptions about Joe's education, occupation, alcohol and drug behavior, family life and sexual behavior. Despite some evidence from Joe to the contrary, the doctor appears to have used these cultural assumptions to create a negative picture of Joe. The doctor's discourse behavior further displays a pattern documented in the literature--that when doctors "dislike" patients they control the medical interview so as to exhibit a narrow orientation to health care (Fisher and Groce, 1985). They focus on patients' presenting complaints to the exclusion of other medical problems which may emerge during the interview.

To appreciate fully how the doctor's typification of Joe affected the outcome of the interview, consider the treatment decision the doctor ultimately reaches:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: it's pretty high [blood pressure] //and uh I think it's got to come down quite a bit before we can consider yourself safe to do any kind of work or for you to be out on the streets uh high blood pressure damages blood vessels and when it's as high as it is now for you it may damage blood vessels so seriously they might even rupture and uh the biggest danger of having high blood pressure as high as you've got it would be a stroke	P: yeah that can be scaring me it can make you have a stroke	P: //yeah
D: that's something we want to prevent we want we don't want people going out and having a stroke//I I believe the best place for you until your blood pressure comes down would be in the hospital maybe you shouldn't go home tonight maybe you should stay here with us and let us get your blood pressure down where it's safe to release you and		P: //uhm

send you back to
work you do want
to get back//on
your job

P: //uh

.
.
.

D: well why don't we
go ahead and get
you in the hospital P: yeah

D: is that alright with
you P: yeah

D: okay I'll go ahead
and get the papers
and get started and
while we're doing
this we'll also
check you for
gonorrhea just to
make sure//but uh P: //uhhuh
most important thing
is to get your blood
pressure down P: okay

The doctor has in effect "washed his hands" of Joe. He decides that what Joe really needs is to be admitted to the hospital for treatment of his high blood pressure. Again indicating reference to cultural assumptions, he adds that it's not safe for Joe to be "out on the streets." Notice, too, that the doctor once again emphasizes that he will check Joe for gonorrhea. This, however, never happens. In fact, no further mention is ever made of Joe's problem with pain on ejaculation or any of the other problems that surfaced during the interview. The doctor has treated Joe as if these problems never existed by always focusing on the high blood pressure problem. To underscore the full impact of the doctor's typification of Joe on the outcome of the medical interview, I have

included verbatim the doctor's entry into Joe's new file at the clinic:

44 year old BM [black male] is referred from the Red Cross nurse of health department for a problem of hypertension. Exam reveals his BP [blood pressure] is around 210/130 and he is admitted for workup of the etiology of this hypertension and to get started on therapy.⁹

A lot more has gone on in this medical interview than is reflected in the doctor's file dictation. The doctor makes absolutely no mention of Joe's catheterization, the fact that Joe threw up a large quantity of blood, his ulcer or his problem with pain on ejaculation. From the beginning of the interview to its end, the doctor's main concern has apparently been with Joe's presenting complaint. The doctor's emphasis is on presenting complaint to the exclusion of all of Joe's other medical problems, coupled with the numerous assumptions about Joe as a person which were displayed in the discourse, point strongly to the conclusion that the doctor does not like Joe and would rather not deal with him. The doctor ends the interview by declaring Joe "unsafe" to be "out on the streets" and sends him to the hospital.

For purposes of comparison, I will now examine a case in which the same doctor appears to evaluate a different patient positively. The patient in this case is Bill, a twenty-year-old white man. Bill has come to the clinic for a premarital physical examination. A picture of the kind of person Bill is begins to develop at the outset of the medical interview:

⁹After each medical interview, doctors at the clinic dictate their impressions, diagnoses and treatment decisions. Secretaries then type the dictations and other personnel insert the sheets into the patients' files.

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: you were scheduled to see Dr. _____ but he's pretty much under the weather today I'm Dr. _____ so I'm going to see you//so uh we'll just sorta get down to business here now you're you're pretty much here just for a premarital physical exam	P: right	P: //alright D: okay
D: do you have anything in specific that you wanted uh checked out or did you pretty much want a top to bottom type of deal	P: just the regular //physical	D: //okay
P: you don't have to do a complete physical do you	D: uh well no I don't have to	P: I just as soon not have one of those
D: so well did someone instruct you to come here to do this or did you feel it was your duty to your bride-to-be	P: I just wanted uh to make sure I was uh okay before we got married	D: okay
D: yeah I think it's a good idea to make sure you don't have any uh diseases you could pass on//to uh your offspring even to uh your bride for that matter		P: //yeah P: right

There are a number of interesting observations in these initial exchanges. First, the doctor's question--"Do you have anything in specific that you wanted checked or did you pretty much want a top to bottom type of deal?"--is somewhat unusual. Typically, when patients come to the clinic for physical examinations, doctors immediately begin gathering medical history information. In this instance, the doctor appears to be giving Bill a choice. After Bill says, "Just the regular physical," he goes on to qualify by explaining that he really does not want a "full" physical examination. It seems that without either one saying so, both Bill and the doctor are talking about the same thing. Bill appears to be indicating that he would prefer not to have a rectal examination and the doctor's "Well, no, I don't have to [give a complete exam]" appears to indicate that the doctor feels Bill does not need one. From my observations at the clinic and from informal discussions with doctors, it is clear that young male patients abhor rectal examinations. It is also clear that doctors routinely skip rectal exams on young men patients who appear to be otherwise healthy. By agreeing with Bill that a "full" physical examination is unnecessary, the doctor is at least initially forming a picture of Bill as a normal, healthy, twenty-year-old man.

The doctor's second question to Bill--"Did someone instruct you to come here to do this or did you feel it was your duty to your bride-to-be?"--is also interesting. The doctor most likely already knows the answer to his own question because the state in

which this interview takes place does not require a physical examination for a marriage license (only a blood analysis). Bill promptly validates the doctor's assumption: "I just wanted to make sure I was okay before we got married." The doctor then acknowledges the appropriateness of Bill's concern with his opinion that: "I think it's a good idea to make sure you don't have any diseases you could pass on to your offspring, even to your bride for that matter." I suggest that even though this whole exchange is somewhat unusual, it serves to indicate a positive picture of Bill to the doctor. Bill has, in effect, done a "noble" thing; even though the state does not require it, Bill wants to make sure he has a clean bill of health before he gets married.

Later in the interview, the doctor displays more assumptions about the kind of person Bill is:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: how long has it been since you've had a physical exam or is this your first	P: it's been since I played football in high school so I'm due for one anyway	
D: okay how old are you now	P: 20	
D: 20 years old	P: yes	

In this excerpt, the doctor displays a cultural assumption about Bill. Notice the phrasing of his question. He says, "How long has it been since you've had a physical exam?"--which is the typical form of questions of this type. But then the doctor goes on to

add: "Or is this your first?" This question is very unusual; nowhere in the other interviews did doctors ask patients similar questions. I suggest that the doctor's question displays an assumption that since Bill is a healthy-looking twenty-year-old white man, this could in fact be his first physical. Bill quickly explains that this is not his first physical and, in so doing, provides the doctor with additional information which may help create an even more positive picture. Not only is Bill normal and healthy-looking, but he also participated in "typical" activities for healthy high school men--he played football.

As the medical interview progresses into the medical history phase, the discourse displays more of the doctor's cultural assumptions about Bill:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: well uh let's just go through your medical history you haven't had any serious diseases that caused you to be hospitalized	P: none at all	
D: any surgeries	P: I had my tonsils taken out when I was a kid	D: okay
D: uh haven't had any blood transfusions or problems associated with that	P: no sir	
D: are you a smoker do you smoke cigarettes	P: nuhhuh	
D: do you drink much liquor	P: yeah I drink	

liquor every now
and then//not
heavy

D: //every now
and then

D: nothing like a bottle
a day or something
like that

P: uh no

D: okay anybody in your
family any uh serious
medical problems
either of your parents
have anything like uh
heart attacks or
strokes high blood
pressure

P: none at all

.
.
.

D: okay well why don't
you take your shirt
off there and I'll
just listen to your
heart and lungs I'll
just sorta dispense
with this as quickly
as possible

P: yeah

Notice how the doctor begins the medical history phase of the interview. He asks Bill: "You haven't had any serious diseases that caused you to be hospitalized?" The form of this question is atypical--atypical because it already presumes a negative response. Doctors normally phrase the question as, "Have you ever had any serious diseases that caused you to be hospitalized?" Why the change in form? Possibly because once again this signals a cultural assumption on the doctor's part--that healthy-looking, athletic, twenty-year-old white men probably have not been hospitalized too often with serious diseases. The same interpretation holds true for the doctor's

question about blood transfusions. Notice also the doctor's questions to Bill concerning alcohol use. His first question is phrased in such a way as to presume alcohol consumption, and a specific type of alcohol at that: "Do you drink much liquor?" Bill's response--"Yeah, I drink liquor every now and then"--validates the doctor's assumption. Though Bill's and Joe's interviews both contain atypical questions concerning alcohol and/or drug use, the assumptions generating these questions appear to be curiously different. Remember that in Joe's case, the doctor's assumption of alcohol/drug use was part of a negative evaluation of the patient; in Bill's case, the opposite would appear to be true. It is as if the doctor is assuming that it is perfectly normal for middle-class, athletic white men to drink. The phrasing of the doctor's next question seems to bear out such an interpretation. After Bill admits to drinking liquor "every now and then," the doctor says, "Nothing like a bottle a day or something like that." The way in which the doctor phrases the question suggests that what he is really saying is, "I'm sure you don't drink a bottle a day or anything like that."

The final portion of the excerpt further suggests that the doctor is in process of constructing a positive picture of Bill. His question, "Either of your parents have anything like heart attacks, or strokes, high blood pressure," displays a cultural assumption. The second assumption is that Bill's family is "normal" in that, since he is twenty years old, both of his parents are still living. Typically, doctors ask patients, even patients younger than Bill,

if their parents are still living. The doctor does not do this with Bill and even uses present tense (have), thereby assuming that Bill's family is intact. Finally, as the doctor begins the physical examination portion of the medical interview, he further intimates that Bill is an "okay," healthy, "normal" man by declaring, "I'll just sorta dispense with this as quickly as possible."

The final bit of information that seemingly helps the doctor's evaluation of Bill comes out later in the physical examination phase of the interview:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: teeth look pretty good look like you've uh bitten your jaw quite a few times// you ever	P: I had braces you know I got when I played football// and got my jaw busted and a lot of that skin in there is kinda tough	P: //uhhuh D: //yeah D: yeah it looks like it

While not extraordinary in any sense, the information transmitted during this exchange does contribute to a picture of Bill as a normal, middle-class young man. While the doctor is examining Bill's mouth, he comments on the roughness of the insides of Bill's cheeks. Bill explains that the roughness is due to the fact that he used to wear braces and has only recently (within the last couple of months) gotten them off. While the doctor does not directly comment on the braces, I suggest that the information about braces fits with

the overall picture of Bill the doctor has been developing. With this last bit of information the doctor now has enough data available to construct a well-rounded positive picture. Bill is a healthy, athletic, twenty-year-old man who is about to be married; he is highly conscientious and considerate of his bride to be, as he is paying for a non-required physical examination to make sure he is "okay"; he drinks, but probably does so within the acceptable limits for a normal American man; and he comes from a normal, intact nuclear family whose parents are at least well off enough to afford braces for their son.

So far I have argued that the discourse displays some cultural assumptions that the doctor has made concerning the type of man Bill is. Bill has contributed to the developing picture by providing the doctor with certain medical and social information. I have suggested that the result is that the doctor has made a positive evaluation of Bill--he likes him. The remaining question is how this picture, once developed, may influence the delivery of health care to Bill. Remember that in the analysis of Joe's medical interview, the doctor's apparently negative evaluation of Joe had some serious consequences for the care which Joe received. The doctor adopted a very narrow orientation to health care by treating only Joe's presenting complaint (and in the end, effectively not treating even that by sending Joe over to the hospital). We see the doctor adopt a very different orientation toward health care, a much wider one, in Bill's case. As Bill's interview nears the end of the physical

examination phase, Bill volunteers additional information about a new medical problem, possibly his "hidden agenda" (Fisher and Groce, 1985):

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: had any ear problems ringing in your ears//that kind of stuff any problems with your hearing where do you work	P: I'm an electrician over here at the hospital	P: //that's the only problem D: oh okay
D: you're here all the time	P: yep	
P: I do have a rash or something that I need you to check out I've had it for about a month	D: okay we'll check it out	
P: that's one of the main reasons I just I just wanted to get that checked//make sure it wasn't nothing		D: //okay that sounds reasonable
D: where is it right there where uh your uh underwear	P: yeah it's right around the hairline sorta	
D: you you got it anywhere else	P: no nuhhuh that's it	
D: does it itch or bother you in any way	P: not at all it doesn't even bother me	D: okay

At the beginning of this excerpt, the doctor is asking Bill about his ears. He then asks a seemingly out of place question about Bill's occupation. After a brief exchange concerning Bill's line of work, Bill takes the floor and announces to the doctor: "I do have a rash or something that I need you to check out." The doctor immediately focuses on what amounts to a secondary topic and pursues it fully by asking standard information-gathering questions. He then proceeds to examine the rash:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: why don't you go ahead and lay back and just loosen your pants there and I'll check out that rash while you're lying down . . .		
D: they've never hurt	P: oh no they really don't can't tell it's there//that's the only place it is	D: //uhm
D: it's not on your backside anywhere	P: no ()	
D: it's not down on your //penis or scrotum	P: //it's not on the penis no	
. . .		
P: it's kinda got me worried I don't know what the hell they could be	D: yeah	

D: yeah well I'm going
to see if Dr. _____
is out there see if he
would come in and take
a look see he's one of
our staff doctors and
he's had more
experience dealing
with rashes and that
kind of stuff than I
have

P: yeah I'd kinda
like to get that
taken care of

The doctor is devoting his full attention to the patient's hidden agenda. Apparently he feels that he cannot make a proper diagnosis unassisted. The doctor leaves the examining room to consult with one of the staff physicians who are at the clinic specifically to assist the residents.

After approximately ten minutes' delay, the doctor reenters the examining room ready to make a diagnosis:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: they're not really venereal warts but they're close		
P: nothing venereal	D: no but you can still catch it from other people but its not	
.		
.		
.		
D: it's a viral infection and you can catch it from people you can catch it from clothes you know and it is contagious I mean you		

know other people can
catch it from you and
you getting married
soon well you want to
get rid of this because
your wife can catch it

P: uhhuh

.
.
.

D: some folks will just
scrape them off
without any
anesthesia

P: well just scrape
them off

D: the only problem with
scraping them off is
down in the hairline
that will make it a
little more difficult

P: alright I
appreciate it
doctor

D: uh just sit sit down
sit back down there
and let me go get a
curet to start
scraping those things
off alright otherwise
you're in real good
health

P: sounds good

After his brief discussion with the staff physician and little more examination, the doctor explains to Bill that he has a viral infection (molluscum contagiosum). Bill seems quite relieved when the doctor tells him although they resemble venereal warts, they are not venereal. The curious thing about this excerpt is that the doctor never really questions how Bill got the viral infection in his pubic area. He goes to great lengths to explain that they are contagious and hints that they can be transmitted sexually--thus his emphasis

on the need to remove them so Bill's bride-to-be won't get them. But if it is possible for Bill to transmit the infection to his wife through sexual contact, is it not possible that Bill got the infection the same way? Yet, the doctor never questions Bill about his recent sexual history. I suggest that this is yet another manifestation of cultural assumptions the doctor has about the kind of person Bill is. Given the information the doctor has gathered about Bill, I believe the doctor has decided that it is unnecessary to take a sexual history. Since Bill is such a fine, upstanding young man who is about to be married, he must surely have gotten the infection through non-sexual contact.

Finally, it is interesting to analyze Bill's "official" medical record in the clinic's files. Remember in Joe's case the doctor negatively evaluated him, treating only his presenting complaint (to the exclusion of other medical problems) and rendered the briefest possible summation of the interview in the file. Contrast that with Bill's case. The doctor has evaluated Bill positively and has gone to great lengths to give him a thorough exam (his presenting complaint) and to treat his hidden agenda. Notice now how extensive Bill's file record is compared to Joe's. Once again, the doctor's dictation is copied verbatim:

Bill is a 20 year old electrician employed at _____ who comes in today for a premarital PE [physical exam]. His only complaint at this point is of a rash which has been present on his lower abdomen for a month. He states the rash has not been painful, nor has it itched. His RPR was nonreactive. PMH [previous medical history]

significant only for tonsilectomy and bilateral tubes in the ears at the age of approximately 12. No chronic disease that he knows of.

- Social history: He does not smoke and only drinks occasionally.

Family history: Essentially negative. He denies any history of diabetes, heart disease, high BP or congenital birth anomalies.

ROS: States he has diarrhea once to twice a week that consists of only a loose stool and is not watery.

Exam: HEENT: TM's are scarred bilaterally and appear thickened. PERRL. EOMI Fundi benign.

Mouth: There are white lesions on both buccal mucosa that seem to be from chronic chewing or biting and also from braces that were removed 6 months ago.

Neck: No nodes or masses. There is full ROM. Thyroid gland normal. Lungs clear to auscultation. Heart: NSR without murmur or gallop. Abdomen: Observation reveals a papular erythematous rash on the lower abdomen. Multiple lesions are apparent. They appear somewhat pustular in nature and are in various stages of healing. Exam under microscope reveals several of these to be umbilicated with a depression in the center. Bowel sounds are normal. There are no abnormal masses.

Genitalia: Normal circumcised male with no evidence of lesions on the penis or scrotum. No evidence of herniation. Extremities normal. No edema or cyanosis.

Neuro exam grossly intact.

A: Healthy 20 year male

Molluscum contagiosum of the lower abdomen.

P: The molluscum contagiosum lesions were scraped with a skin curet. He was given his OK of a clean bill of health for his marriage. He is to return p.r.n. (as needed) basis. He was also warned that his wife could possibly have some of the lesions of the molluscum contagiosum and should she require treatment for this she can come and have this done.

Bill's medical record stands in marked contrast to Joe's. Whereas in Joe's record nothing that went on in the interview has been recorded, virtually everything that was talked about in Bill's interview has been included in his file.

Cultural Assumptions and the Structure of Medical Interviews

As we have seen, the cultural assumptions doctors make about their patients as men can affect the social construction of treatment decisions. These cultural assumptions also appear to have an effect on the structure of medical interviews, the manner in which doctors and patients communicate with each other during the various phases of the interview. Recent research on medical communication suggests that doctors' raw word output during medical interviews is positively correlated with outcome variables such as patients' compliance with medical regimens and their levels of satisfaction with medical consultations (Freemon et al., 1971; Pfefferbaum et al., 1982; Slavin et al., 1982). Quantification of doctors' communication might reflect the operation of assumptions they have made about their patients.

Table I presents an empirical view of how the doctor in these interviews exchanged information with Joe and Bill. From Table I we see a quantitative difference in the ways this doctor offers and responds to information with his patients. He clearly communicates more with Bill than he does with Joe. In the opening phase he initiates communication with Bill at an average of 16.5 words per utterance. His average words per initiation with Joe are almost three times less (5.9 words per initiation).

We see similar patterns in the medical history phase. The doctor is asking both patients medical and social questions as he tries to establish each patient's personal and family history, but he is still communicating more with Bill than with Joe. Even when

TABLE I
DOCTOR'S WORD OUTPUT ACROSS PHASES OF THE MEDICAL INTERVIEW

Phase	Joe		Bill	
	Words/ Initiation	Words/ Response	Words/ Initiation	Words/ Response
Opening	5.9	0*	16.5	13.3
History	8.1	4.3	11.8	7.3
Exam	11.3	7.0	12.7	12.3
Closing	16.6	7.4	39.0	10.0

*The patient made no initiations in these phases.

Bill and Joe take the floor to volunteer information, the doctor responds to this information differently. He responds at an average of 7.3 words per response with Bill and at an average of only 4.3 words per response with Joe.

The doctor is typically in control of the interaction during the physical examination phase of the interview. This control is reflected in the fact that his initiations are greater than his responses for both Bill (12.7, 12.3) and Joe (11.3, 7.0). But notice the difference in his response patterns for the two patients. Even though it is atypical (and thus deviant) for patients to take the floor during the physical examination phase to volunteer information, this doctor responds at length to Bill (12.3 words per response) while he does not with Joe (7.0 words per response).

The closing phase of the two interviews reveals a large discrepancy in the doctor's pattern of communication with these patients. At a time in the medical interview when the doctor usually talks at length, summing up his findings and suggesting treatment decisions, notice how little he talks to Joe. He initiates communication at an average of 16.6 words per utterance. It may seem as if the doctor is providing Joe with a large amount of information--until we compare that 16.6 words per utterance with his 39.0 words per utterance in Bill's interview. Table I clearly demonstrates that the doctor communicates more information to Bill than to Joe.

The differences in the doctor's patterns of communication with his patients is displayed in Table I. While we might conclude that personality or contextual variables account for these differences--perhaps the doctor was wrapping up an exceedingly long day and was tired (did not feel like talking much) when he encountered Joe--the analysis contained in the preceding section suggests otherwise. It would appear that doctors' evaluative perceptions of their patients influence the emerging structure of medical interviews--how information gets offered and responded to. It appears, too, that the way information is exchanged between doctors and patients (or is not exchanged, as in Joe's case) influences the quality of health care patients receive. The doctor did not communicate much with Joe and Joe subsequently left the clinic without any of his medical problems addressed or taken care of. On the other hand, the doctor communicated much more with Bill. Bill, as we know, left the clinic with all his questions answered and his problems treated.

We may also begin to see what effects doctors' cultural assumptions about their patients have on the social construction of medical interviews by looking at how doctors talk with patients about the medical topics which arise in the course of medical interviews. Typically, doctors and patients communicate on a variety of topics during an interview--the patient's presenting complaint (why he came to the clinic), his hidden agenda (a reason for coming to the clinic that the patient does not immediately share with the doctor, but mentions later in the interview) and a number of other topics which usually emerge during the medical history phase. Table II presents the pattern of doctor-patient communication on two selected topics which seemed to be of most importance to Bill and Joe.¹⁰ Fisher and Groce (1985) developed a statistic, the RIR, to aid in the interpretation of doctors' and patients' word outputs during medical interviews. The RIR is the "response-initiation ratio" which is computed by dividing doctors' responses by patients' initiations. It displays how many words of response a doctor utters per every 1.0 words of a patient's initiation.

¹⁰The decision as to which topics were most salient or important to Joe and Bill was made on the basis of number of utterances. In addition to Joe's presenting complaint (high blood pressure) and pain on ejaculation, Joe and his doctor discussed his ulcer, his shortness of breath, his catheterization and his problem of vomiting blood. In addition to the premarital physical examination and venereal warts, Bill and his doctor discussed abrasions in Bill's mouth which were due to braces. In each instance these tertiary topics were not discussed in much detail as the ones analyzed. They exhibited noticeably fewer and shorter initiations and responses.

TABLE II
COMPARISON OF PATIENTS' INITIATIONS AND DOCTOR'S RESPONSES BY TOPIC

Topic	Words/Initiation	Words/Response	RIR
		JOE	
Presenting Complaint	16.8	4.5	0.27
Pain on Ejaculation	18.2	11.0	0.6
		BILL	
Presenting Complaint	25.8	18.7	0.72
Warts	22.1	24.5	1.11

Notice the doctor's apparent willingness to talk about Bill's presenting complaint--his need for a premarital physical examination (RIR = 0.72). Notice also his apparent unwillingness to discuss Joe's presenting complaint of abnormally high blood pressure (RIR = 0.27). In fact, the doctor appears unwilling to discuss either Joe's presenting complaint or one of the most important topics which emerged during the interview, Joe's pain on ejaculation. At the same time he provides much more response to Bill's initiations about his presenting complaint (premarital physical exam) and his hidden agenda, the warts on his lower abdomen. As before, the explanation would seem to lie in the fact that the doctor has used cultural assumptions to form evaluative perceptions of Joe and Bill, perceptions which influence the structure of discourse in the medical interview and the delivery of health care.

Cultural Assumptions About Male and Female Patients

We may now begin to draw some initial conclusions concerning patients' and the negotiations of cultural assumptions in medical interviews. The first thing we notice is that doctors appear to display cultural assumptions about men less than they do about women. Fisher and Groce (1985:348) report that 67.4 percent of their interviews between doctor and female patients displayed cultural assumptions. My research on doctors and male patients indicates the displaying of cultural assumptions in only 53.5 percent of the cases. This finding may be explained by the fact that doctors tend to accord

male patients higher status than female patients. As Barr (1983) has suggested, doctors' tendencies to make negative evaluations of their patients decrease as the social distance between doctors' status and patients' status decreases.

We may also note an interesting status difference when we look at what kinds of cultural assumptions doctors make about male and female patients. In Fisher and Groce's data, doctors displayed cultural assumptions about women as patients in 42.9 percent of the cases, while they displayed assumptions about women as women in the remaining 57.1 percent. In the interviews between doctors and male patients, doctors displayed assumptions about men as patients in only 13.0 percent of the cases. The other 87.0 percent of the cases were cultural assumptions about men as men. These findings suggest a pattern concerning patients' master status in medical interviews. It would appear that when women go to doctors, their doctors are almost equally as likely to make assumptions about them as patients as they are to make assumptions about them as women. This is not the case with men. The data clearly demonstrate that with men, the master status is "man" and not "patient."

There appear to be two areas in which a patient's gender makes no difference in the negotiation of cultural assumptions. One of these areas is the range of cultural assumptions. That is, doctors appear to make the same types of cultural assumptions about their patients as people. They make assumptions about patients' work, lives, family lives, sexual behavior and drug/alcohol consumption

patterns regardless of patients' gender. Also doctors' uses of cultural assumptions have the same net effect on treatment decisions for both female and male patients. When doctors evaluate patients of either gender positively those patients receive adequate health care; when the evaluations are negative, the quality of health care is questionable (see Fisher and Groce, 1985 for a discussion of assumptions and the quality of health care for female patients).

Finally, we may examine how cultural assumptions affect the raw word outputs in interviews between doctors and female patients and doctors and male patients. Fisher and Groce (1985) analyzed doctors' cultural assumptions about their patients as women. When we compare Fisher and Groce's data with mine we get the results shown in Table III, which indicates a slight tendency for doctors to communicate more with female patients than male patients when both have been evaluated positively. Their words per initiation and words per response values are highest for interviews with female patients in the opening, medical history and closing phases.¹¹ This tendency is quite pronounced in the medical history phase (47.4 and 111.8 words per utterance with women patients, 11.8 and 7.3 words per utterance with men patients. The table suggests a slightly different pattern when doctors evaluate their patients

¹¹We have no comparable data on female patients for the physical examination phase. The communication between doctors and female patients during the exam phase in Fisher and Groce's (1985) analysis were not tape recorded.

TABLE III

COMPARISON OF DOCTORS' WORD OUTPUT ACROSS PHASES OF THE MEDICAL
INTERVIEW WITH MALE AND FEMALE PATIENTS
EVALUATED POSITIVELY AND NEGATIVELY

Phase	Male Patient		Female Patient	
	Words/ Initiation	Words/ Response	Words/ Initiation	Words/ Response
POSITIVE EVALUATION				
Opening	16.5	13.3	17.7	14.0
History	11.8	7.3	47.4	111.8
Exam	12.7	12.3	--	--
Closing	39.0	10.0	31.5	0
NEGATIVE EVALUATION				
Opening	5.9	0	6.4	5.0
History	8.05	4.3	6.7	16.4
Exam	11.3	7.0	--	--
Closing	16.6	7.4	13.9	16.7

negatively. The data indicate that doctors talk more with female patients whom they have evaluated negatively than with male patients in the opening phase of the interview. This pattern appears to reverse during the other phases of the interview. Table III also suggests that while doctors initiate communication with negatively evaluated male patients at a higher rate than with female patients, they respond in more detail to male patients.

An interesting pattern emerges when we compare RIR's for interviews with men and women patients. Recall the values for Joe and Bill in my data: 0.27 (Joe's presenting complaint), 0.6 (Joe's pain on ejaculation), 0.72 (Bill's presenting complaint) and 1.11

(Bill's warts). Fisher and Groce (1985:366) report a strikingly different set of RIR values: 4.3 and 3.0 for presenting complaint and hidden agenda of a negatively evaluated female patient and 1.7 and 8.0 for presenting complaint and hidden agenda of a positively evaluated female patient. These findings suggest that doctors communicate more with female patients than male patients on important topics regardless of whether the patients get evaluated positively or negatively.

Cultural Assumptions Treatment Decisions

The in-depth analysis of these two medical interviews indicates that the doctor produced two very different pictures of Joe and Bill as men. In the process of constructing these pictures, the doctor displayed commonly held cultural assumptions about these patients. Both doctor and patients negotiated these assumptions throughout the medical interviews while discussing a variety of both medical and social topics. In Joe's case, the negotiation of cultural assumptions culminated in the doctor's negative evaluation of Joe; the doctor in the second case constructed a positive picture of Bill.

In both cases, the negotiated typifications influenced the delivery of health care to patients. Joe came to the clinic with abnormally high blood pressure. While this is obviously a valid medical problem in its own right, Joe did inform the doctor of several other serious and potentially serious conditions/problems

during the medical interview. Joe left the clinic without a follow-up of his bladder catheterization, without the doctor attempting to establish why he threw up such a large quantity of blood, without any discussion of or treatment for his problem of pain on ejaculation. Furthermore, the doctor opted not to treat Joe's high blood pressure by convincing him that he should be in the hospital and not "out on the streets," and the doctor failed to include any pertinent information about Joe's overall health in the official medical record.

In contrast, Bill came to the clinic for a premarital physical examination. As the medical interview unfolded, it became clear that Bill had a definite hidden agenda--he was worried about a series of bumps in his pubic hair. The doctor fully treated both problems. Bill left with a complete physical examination (minus the rectal exam which, at his age, was not necessary); he also left with hidden agenda treated. The doctor diagnosed the bumps as non-venereal (which Bill was obviously concerned about) and took time to scrape them off. Finally, the doctor constructed a very detailed and thorough record of the medical interview.

The negotiation of cultural assumptions about men and the effect of these assumptions on medical treatment decisions have been analyzed as interactional accomplishments between doctors and patients. It should be emphasized again that doctors and patients are not equal interactional partners during medical consultations. The institutional authority of the medical role gave these residents an advantage which was displayed in the communication. Presumably,

Joe and Bill came to the clinic with what they defined as medical problems. During the interviews while doctors questioned and patients answered, Joe and Bill presented social as well as medical pictures of themselves. It is reasonable to assume that these patients were not cognizant of the fact that the doctors were constructing evaluative pictures of them or that these evaluative pictures ultimately influenced the delivery of health care. Yet the data strongly suggest that the doctor did indeed differentially evaluate and treat Joe and Bill: doctors' cultural assumptions were displayed in the discourse; the patients presented bits of information that validated some of the assumptions and invalidated others; Joe's doctor displayed numerous instances of code-switching while Bill's did not; the patients' hidden agendas were differentially discussed and treated; the treatment decisions displayed different degrees of adequacy and thoroughness; and the "official" medical records of the two patients were markedly different in terms of accurately reflecting what actually transpired during the two interviews.

This analysis underscores an important feature of cultural assumptions about patients as men. The assumptions or norms about men share a reflexive relationship (Fisher and Groce, 1985; Groce and Fisher, 1984) with the interactional work doctors and patients do to produce them in medical settings. The cultural assumptions doctors make about patients as men do not exist "out there" in some independent, objective reality; nor do doctors construct anew fresh assumptions each time they interact with men patients. Rather,

"cultural assumptions and communication function as context and ground in the social production of both medical discourse and medical outcomes" (Fisher and Groce, 1985:34). That is, the set of commonly held assumptions about "what men are like" in our society informs, influences and directs the interactions between medical practitioners and men patients and the treatment decisions they produce. At the very same time, the interaction between doctors and patients reproduces and reflects these commonly held cultural assumptions.

Cultural Assumptions and the Social Construction of Reality

By understanding the reflexive relationship between cultural assumptions about patients as men and the medical interactions between doctors and men patients, we are in a position to draw conclusions at the level of sociological theory. Sociologists have long held social action to be one of the discipline's foundational concepts. Theorists have routinely questioned how social actors come to behave appropriately and have constructed various theoretical accounts linking behavioral norms to social action. Parsons' (1954) explanation focused on a shared set of norms internalized by individuals. Durkheim (1938) emphasized a collective consciousness shared in an external world. Marx (1964) argued that a society's economic infrastructure informed and constrained behavior.

These and other theorists have long argued that norms govern social action. Their position has been met with revision and criticism from Wittgenstein (1953), Winch (1958), Gurwitsch (1964) and others.

Ethnomethodologists such as Garfinkel (1967) and Cicourel (1974) have sought to redefine and extend the concept of normative action. Garfinkel argues that individuals actively construct their behavior. They are not "judgmental dopes" who merely internalize a set of deterministic norms. Rather, individuals act as "secret apprentices" who ferret from interactions the information necessary for appropriate action. While Garfinkel hints at a relationship between norms and social situations in the construction of behavior, he does not specify it. Cicourel (1974) does, however, by addressing the relationship between process and structure. He argues that norms are interpreted within emergent action scenes, thus explaining how individuals decide which norms are relevant for particular social situations.

Thus, by placing cultural assumptions or norms about men and the work participants do to interactionally produce them in a reflexive relationship, it is possible to begin to link what have traditionally been considered disparate sociological orientations. As Knorr-Cetina and Cicourel (1981) have observed, the analysis of social interaction (micro-sociology) and the analysis of social structure (macro-sociology) have generally been defined as incompatible. By considering interactions between doctors and patients in its broader social context, it is possible to recast seemingly opposite macro and micro orientations in such a way that social structure and social interaction become reflexive--each flow from and are a part of the other (Mehan and Wood, 1975). As Fisher and Groce (1985:36) have noted:

On the one hand, the social and political milieu of the culture we live in informs the discussion of the social production of medical discourse and medical outcomes. On the other hand, an understanding of the social production of medical discourse and outcomes illuminates how these are shaped by larger structural and institutional forces which in turn reproduce them. The analysis of discourse during medical interviews is strengthened by posing social structure and social interaction, context and ground, in a reflexive relationship with one another.

From a macro or structural perspective, we find work describing the doctor-patient relationship as a result of the organization of the social structure. This work shares a common assumption, namely that the nature of the doctor-patient relationship is caused by structural or institutional factors. Similarly, the communication between doctors and patients is viewed as a way of maintaining power differentials in a society which is dominated by gender and class and a medical profession which reflects this domination (Wallen et al., 1979; Navarro, 1976). Doctor-patient communication is thus seen as a result of the structural arrangements of society.

From an interactional orientation, researchers analyze the doctor-patient relationship and the communication therein as social productions. The focus here is on process. Social actors use language to produce meaning in specific contexts (Davis, 1963; Millman, 1976; Bosk, 1979). Scully (1980) and Luker (1975) discuss how the interrelationships of roles, values and attitudes create and maintain social realities. Finally, some researchers in medical settings investigate the social organization of doctor-patient communication, how doctors and patients together produce medical discourse (e.g., Fisher and Todd, 1983).

I have attempted in this chapter to recast the problem. Following Fisher and Groce (1985) I have argued that social structure and social interaction are not separate. I have tried to show how the analysis of the negotiation of cultural assumptions about men allows us to see that social structure and social interaction flow from each other, that the relationship they share is reflexive. Doctors and patients interact with each other in an on-going process of negotiation and interpretation which is located within a social situation informed and influenced by the larger structure of society. By examining the discourse which doctors and patients produce within this context, we see how both the structure of the medical relationships and doctors' cultural assumptions about patients as men are simultaneously social facts and socially emergent realities. In Joe's and Bill's medical interviews the doctor displayed his knowledge of cultural assumptions (norms) about Joe and Bill as either "good" or "bad" men. This represents a knowledge of "social facts." During the interview both doctor and patients also displayed the interactional work which produced these cultural assumptions. The medical interviews, then, provided the context in which cultural assumptions emerged, were displayed and were acted upon. I take this process as a socially organized production which is accomplished through the interactional work of the participants.

The reflexive analysis of medical interviews also highlights how the asymmetry of the doctor-patient relationship is simultaneously both a social fact and an interactionally produced social reality.

The medical profession is highly autonomous (Freidson, 1970). Autonomy leads to monopoly which in turn leads to social control (Fisher and Groce, 1985; Ehrenrich and Ehrenrich, 1978; Zola, 1978). While these are the social facts of the medical relationship, the picture is incomplete. By virtue of autonomy and monopoly, doctors control medical knowledge and technical expertise (Shuy, 1983). They also control medical interviews by controlling patients' access to information (Waitzkin, 1985; Quint, 1972; Paget, 1983; West, 1983) and health care services (Fisher, 1983; Todd, 1983; Fisher and Groce, 1985). Their power and control is manifested during the process of medical interviews. This was clearly evident in the data in the ways the doctor defined Joe and Bill, controlled the structure of the discourse and the flow of information and influenced the treatment decisions--the interactionally produced social reality of medical interviews.

CHAPTER V

CONCLUSIONS

The preceding analyses enable us to draw two important conclusions about the social construction of medical interviews and treatment decisions between doctors and male patients. The first is that treatment decisions are social interactional events--they are the products of two social actors communicating in a specific situation. While many scholars continue to support hypothetico-deductive psychological models of medical decision-making, we have evidence of what Eisenberg (1978) would call a "sociologic influence" on how doctors actually arrive at treatment decisions. Doctors' evaluative perceptions of their patients, their cultural assumptions about them as people, have a demonstrable effect on how they treat their patients--in terms of both presenting complaints and other medical problems which come to light during medical interviews. When doctors categorize their male patients in a positive manner they deliver full and adequate health care; when they categorize them in a negative fashion the quality of care patients receive becomes questionable at best. What comparative evidence we have for medical interviews between doctors and female patients suggests a similar pattern. Thus, status differences between male and female patients seem to have little effect on doctors' use of cultural assumptions.

The quantitative analysis presented in Chapter IV displayed how doctors' cultural assumptions about their male patients influence the exchange of information during medical interviews. It would appear that when doctors "like" (evaluate positively) their male patients they spend more time communicating with them and providing information to them and vice-versa. The same appears true for female patients, although what comparative data we have suggest that doctors communicate more with female patients than with male patients.

This discussion is not intended to imply that doctors consciously choose to discriminate against certain patients based on gender, race, education or any number of other sociological considerations. In fact, while doctors typically admit to have negative attitudes about certain patients, they typically believe that they treat patients impartially and objectively (Kurtz et al., 1985:1043). Kurtz et al. (1985) argue, and I would have to agree, that a "white coat model" is in operation. That is, due to the rigor with which objectivity and neutrality are stressed in medical school, doctors have a difficult time recognizing and acknowledging their own discriminatory behaviors during medical encounters.

Whether at a conscious or unconscious level, the fact nevertheless remains that doctors' categorizations of their patients do influence the medical decision-making process. I think it is important for us to remember that doctors do not immediately evaluate patients positively or negatively. While doctors' first impressions of their patients are no doubt important (Nordholm, 1980), I have shown that

evaluative perceptions are interactional phenomena--produced, modified and reproduced over the course of the medical interview. Patients continually aid doctors in constructing these evaluations by the information they either provide or fail to provide as the interview progresses. As we saw in the cases of both Joe and Bill, once patients aid doctors in constructing evaluative perceptions, the perceptions have a definite impact on final treatment decisions and ultimately the quality of health care they receive.

The second conclusion we may draw concerns doctors' use of social control as a manifestation of their institutional authority. The medical sociological literature is replete with studies documenting doctors' uses of institutional authority and social control with female patients. We now know that doctors behave in a similar manner with male patients. As doctors accepted, openly rejected or did not respond to their male patients' accounts they were able to continually control the flow of information and, hence, the medical interview. They controlled both the information that was transmitted and the manner in which it was transmitted across each phase of the medical interview.

From comparative data, we now have evidence that as the relative status difference between doctors and patients decreases, so does the frequency of incidences of social control. Doctors openly reject and fail to respond to more female patients' accounts (lower relative status) than male patients' accounts (higher relative status).

The documentation of this manifestation of doctors' institutional authority may permit generalization to broader principles of

sociological theory. Although the present task has been to display some of the features of doctor-patient communication, the issue to be addressed is a larger one. That is, the notion of the influence of institutional authority on the social construction of situational realities may be generalizable to other bureaucratic institutions. As I have mentioned before, structure and process within the medical situation recapitulates larger social situations. When we talk about communication between social actors, we have sociological evidence that status and power affect the communication process (Zimmerman and West, 1975). When we talk about relationships between social actors, we have sociological evidence that social institutions lend authority to their dominant actors (Weber, 1947) and influence interactions (Fisher, 1983). Thus, the question really addresses a form of behavior--the relationship between a social institution, its dominant and subordinate actors and social constructions of reality. The ways in which doctors in this study manifested their institutional authority to retain control of the flow of interaction may suggest similar instances of social control in other institutional settings.

Methodological Notes

As an analytic tool discourse analysis has been valuable in enabling us to see some of the process of reality construction during medical interviews--the interactional work participants do in producing social phenomena recognizable as "medical interviews" and "treatment

decisions." The expansion technique allows us to draw together information from a number of sources simultaneously, thus permitting detailed descriptions about how doctors and patients construct social realities.

Unfortunately, the major strength of discourse analysis is also its major weakness. As I discovered early on, to scrutinize intensively what doctors and patients say to each other, to focus solely on the verbal aspects of human communication, is to slight other aspects of communication which influence the social construction of reality. Most notably, nonverbal cues get left unattended. Doctors' and patients' pitch, rate of speech, tone, eye contact, gestures, body position and the like ceaselessly affect the social interaction process. The most significant improvement in discourse analysis would seem to be some way to fully contextualize what passes between social interactants.

A second methodological note concerns the problem of doing research in a medical setting. More than once during this project I found myself acting and reacting based on preconceived attitudes about doctors, patients, nurses and the entire health care system generally. To a degree this is unavoidable. As everyday members of this society we share certain common socialization experiences which give rise to biased, stereotypical attitudes and beliefs. Perhaps these biases are more noticeable when doing research in a medical setting because of the life-sustaining functions of the health care system. At any rate, I am aware of some of my own biases

and have attempted to minimize their impact on my analysis, although any analysis is interpretation and any interpretation is influenced by prior interpretations.

Directions for Future Research

Conclusions should perhaps be thought of as beginnings instead of endings. Rather than dwelling on what has been accomplished, we should be more concerned with what is left to do. I have sought only to provide some initial descriptions--of the structure of medical interviews between doctors and their male patients and of how doctors and male patients negotiate cultural assumptions or norms about patients as people and how these assumptions affect medical treatment decisions and the delivery of health care. Much work remains to be done. Many variables, issues, considerations must be attended before we can ever say we understand this social construction of reality business.

I see two immediate avenues for future research. The first concerns what might be done with the data I have already gathered. While some research suggests that the severity of patients' presenting complaints affects doctors' treatment decisions, we have no information on how different presenting complaints affect the patterns of communication between doctors and patients. Thus, it would be informative to divide my medical interviews into two groups, chronic and acute presenting complaints. We could then compare how doctors respond to patients' accounts in each group and also doctors' use of cultural assumptions for each group.

The second avenue for future research concerns the gathering of new data. Perhaps the most important task is to explicate the direct effects of patients' statuses as men and women on the social construction of medical interviews and treatment decisions. I have referred repeatedly to the work of Fisher and Fisher and Groce. They have begun to describe in detail how doctors and female patients together construct social realities. I have sought in the present research to do the same with doctors and male patients. While we obviously must begin with descriptive studies which use different patient populations, what we need are studies which simultaneously examine the construction of medical realities with both male and female patients. This would permit direct comparison and, therefore, allow us to isolate the effects of patients' relative status differences on the construction of medical interviews and outcomes.

We also require more research into the sociological factors which influence the treatment decisions which doctors produce about medical interviews. Were we to surgically open up doctors' heads, I doubt seriously if treatment decisions would fall out. That is because, in the end, medical treatment decisions are the result of social processes and influences which are actualized each and every time a doctor and a patient interact in an examining room. I have attempted to begin a description of how one important sociological consideration, assumptions or norms about men, may influence the decisions doctors reach; Fisher and Groce (1985) have done the same thing with female patients. Unfortunately, the negotiation

of cultural assumptions is but one of many pieces in the huge puzzle we call "socially constructing a treatment decision." Future research must be directed toward the identification and description of the ways in which other sociologically relevant variables affect the decision-making process.

In conclusion, I should speak briefly on the question of why--why we should engage in this type of research in the first place. I see two important reasons. The first reason concerns the nature of sociological theory. I find the current movement to link micro and macro in sociological theory refreshing, exciting. It seems to me to be the soundest way in which to develop a "social constructionist" theory of society.

The research reported here contributes to the ever-accumulating store of knowledge about how social actors produce the worlds they live in from day to day. Every incremental increase in our understanding of how doctors and patients produce medical realities to some degree informs us as to how the social construction of reality is accomplished generally; every time we document the use of institutional authority in the examining room we come closer to understanding power and combination as social forms; each time we see differences in the quality of medical care patients receive based on doctors' culturally-produced assumptions, we learn a little more about the nature of stereotyping and discriminatory behavior.

The second reason for doing research of this kind is more practical than theoretical. The ways in which doctors and patients

interact with each other, the ways they communicate, strongly influence the delivery of health care. The ways in which identities are negotiated, the manner in which accounts are offered and responded to, the ways cultural assumptions are negotiated--all these (and more) ultimately contribute to the treatment decisions doctors make "on behalf" of their patients. The medical sociological literature is replete with studies correlating doctor-patient communication with assorted outcome variables (e.g., Korsch et al., 1968; Korsch and Morris, 1969; Daly and Hulka, 1975; Comstock et al., 1982). Given the importance attached to medical communication, my research has the potential to improve doctor-patient interaction and, hence, to improve the quality of medical care. If we can teach doctors to be mindful of their institutional authority, if we can teach them to be aware of and avoid making cultural assumptions about their patients, etc., maybe we can get doctors and patients together to socially construct more positive medical realities. I would agree with Samora et al. (1961:92) when they note that:

Perhaps if the goal of medicine is the diagnosis and treatment of disease, the quality of communication makes little difference, so long as an adequate medical history can be obtained and the necessary cooperation of the patient in doing or refraining from doing certain things can be assured. But if the goal is more broadly interpreted, if the concern is with the person who is sick and the purpose is to relieve, reassure, and restore him--as would seem to be increasingly the case--the quality of communication assumes instrumental importance and anything that interferes with it needs to be noted, and if possible, removed.

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APPENDICES

APPENDIX I

TOWARD A THEORETICAL EXPLANATION OF MICRO- AND MACRO-LINKAGE IN THE SOCIAL CONSTRUCTION OF REALITY

It seems to us as though we had either the wrong pieces or not enough of them, to put together our jig-saw puzzle. But they are all there, only all mixed up It's no use trying to apply force in fitting pieces together. All we should do is to look at them carefully and arrange them.
--Ludwig Wittgenstein

I seek to accomplish two tasks in this appendix, to provide a general theoretical framework for uniting the micro and macro sociologies contained in the reflexive analysis of doctor-patient interviews in Chapters III and IV, and to demonstrate how a reflexive conception of social structure and social interaction can heighten our understanding of how doctors and patients socially construct medical interviews and reach treatment decisions. I will begin by briefly reviewing how other scholars have attempted to recast the micro-macro problem in sociology. I will next offer my theoretical model for understanding the reflexive nature of social structure and social interaction, a model based on what is generally regarded as the writing of the "later Wittgenstein." I will conclude by suggesting how a philosophically informed reflexive sociology can illuminate the processes involved in the social construction of medical interviews.¹

¹For complete discussions on the necessary complementarity of philosophy and sociology see Winch (1958), Merleau-Ponty (1978) and Schulz (1978).

The Micro-Macro Distinction in Sociology

A long-standing tradition in sociology attempts to explain social reality by reference to one of two seemingly opposing levels of analysis, the "micro" and the "macro." There is evidence that the gap between micro and macro levels of analysis has increased over the last two decades (Knorr-Cetina and Cicourel, 1981:xi). Perhaps one reason for the widening gap is sociologists' competing conceptions of what elements constitute a micro- or a macro-phenomenon. Another reason could be the conviction with which sociologists from each position have criticized the theoretical and research endeavors of the other (Collins, 1981:88-92).

To understand better this theoretical disparity, let us examine more closely the concepts of micro and macro. Generally, a micro sociology concerns itself with "face-to-face interaction, with everyday routines and classifications, with strips of conversation, or with definitions of the self and of situations" (Knorr-Cetina, 1981:1). Such a definition would seem to be common to a variety of sociological approaches, including symbolic interactionism (e.g., Blumer, 1969), ethnomethodology (e.g., Garfinkle, 1967; Mehan and Wood, 1975), cognitive sociology (e.g., Cicourel, 1984), social phenomenology (e.g., Schutz, 1967, 1979; Berger and Luckmann, 1967), ethogeny (e.g., Harre and Secord, 1972; Harre, 1974, 1980, 1981), social exchange theory (e.g., Homans, 1961) and the ethnography of speaking (e.g., Hymes, 1968). The underlying assumption in all of these micro positions is

that "social reality" is not a sui generis phenomenon; rather, social reality is conceptualized as an ongoing creation of those who participate in it. Thus, these theoretical positions share an emphasis on how interaction between individuals yields what we experience as "society," an emphasis perhaps most clearly articulated by Simmel (1971:23--originally 1908):

Society exists where a number of individuals enter into interaction. This interaction always arises on the basis of certain drives or for the sake of certain purposes . . . religious or merely associative impulses; and purposes of defense, attack, play, gain . . . [t]hese and countless others cause man to live with other men In brief, he influences and is influenced by them. The significance of these interactions . . . lies in the fact that it is because of them that individuals . . . form a unity, that is a society.

Macro sociology differs from micro sociology in that it concerns "the study of society, of social institutions and of sociocultural change on an aggregate level" (Knorr-Cetina, 1981:2). A macro sociological approach can include both the use of theoretical concepts on a systems level and the use of aggregate data that characterize social collectivities. The underlying assumption of macro sociology is that we may explain and describe social reality as an independent entity--without reference to the social actors who comprise it. Thus, thinkers have at times explained social action and the structure of society as the result of an external and constraining socioeconomic structure (e.g., Marx, 1964), the internalization of a shared normative order (e.g., Parsons, 1954) and moral obligations

and the collective consciousness (e.g., Durkheim, 1938).

Historically, advocates of micro and macro sociology have been highly critical of each other on both theoretical and methodological grounds. Collins (1981:88) has noted that micro sociologists fault their macro counterparts on four counts. Initially, micro sociologists point out that macro sociology is an unexplicated gloss. That is, macro concepts such as social structure do not validate the existence of an empirical, verifiable world that transcends individuals' perceptions of it. Macro sociology is also criticized as a false construction which forces social reality into inappropriate and misleading categories through the use of numerical concepts. Third, macro sociology is "impossible in principle" (Collins, 1981:88) because it examines the everyday grounds of its own construction and reifies its concepts. Finally, macro-events, as described by macro sociology, are seldom part of social actors' experience of reality. From the other direction, macro sociologists have variously criticized micro sociologies as idealistic, trivial, causally contingent and reductionistic.

One of the most recent developments in sociological theory has been an interest in bridging the gap between micro and macro sociologies (Knorr-Cetina and Cicourel, 1981; Cicourel, 1980a, 1980b, 1981; Giddens, 1979, 1981, 1984; Harre, 1980, 1981; Duster, 1981; Collins, 1981; Waitzkin and Stoeckle, 1976; Habermas, 1981; Fisher, forthcoming; Fisher and Groce, 1985; Groce and Fisher, 1984). Writers attempting a theoretical linkage between micro and macro share a

common assumption, namely, that macro social phenomena are essentially unknown and unknowable unless they can be based on an analysis of micro social situations. Thus, the problem of social order is recast, turned on its head. As Knorr-Cetina has argued (1981:7):

Social order is not that which holds society together by somehow controlling individual wills, but that which comes about in the mundane but relentless transactions of those wills. The problem of social order has not only turned into a problem of the cognitive order; it has also turned from a macro-level problem into a micro-level problem of social action.

Or, as Cicourel has observed (1981:54), the micro and macro are never self-contained levels of analysis; they constantly interact with each other to produce the phenomenon of social order.

Once we recast the problem of social order to accept the assumption that "all daily-life settings reflect several levels of cultural complexity" (Cicourel, 1981:52), we are forced to reconsider such supposed "polar opposites" as individual-collectivity, action-structure, etc. The important question then becomes: how do we alter our theoretical thinking to reflect the simultaneous operation of different levels of cultural complexity? Scholars have recently suggested a number of possible approaches. Collins (1981) offers the "aggregation hypothesis," a model of social reality wherein he represents macro considerations as the composition of aggregates of micro situational episodes. These micro episodes are the "building blocks" for sociological theory construction. Collins acknowledges the existence of only three "true" macro level variables--space,

time and number of micro situations. Other variables such as "system," "state," or "society"

turn out to be abstractions without causal reality; at best they are social actors' concepts . . . which have misled sociological theorists into taking them as literally true (Collins, 1981:101-102).

Another attempt at linking micro and macro sociological theory is the "hypothesis of unintended consequences," which Harre (1981) and Giddens (1981) have offered in different forms. In Harre's theoretical model, the unintended consequences of social action constitutes system properties which confront social actors as environments of possible future action. Macro level phenomena like "working class" are emergent and inextricably bound to the everyday lives of the individuals who comprise them. Concepts like "working class" cannot be thought of as having a "life of their own": "In short the supra-individual implications are rhetorical rather than ontological" (Harre, 1981:149).² Giddens' (1981) theoretical model emphasizes the unintended consequences which condition social reproduction. Social systems "exist" and are structured only in their production and

²Harre's hypothesis of unintended consequences is part of his overall program of ethogeny or ethogenics which "involves assembling members' understandings and interpretations of the institutions and events which make up its life and negotiating these with an outside observer's ethnography. To call this 'ethogenic' is to emphasize the normative character of the knowledge and systems of beliefs used by members to act in accordance with rules and interpretations, adherence to which generates the collective" (Harre, 1981:151).

reproduction during micro level social interactions. Essentially, this is Giddens' theory of structuration (1979, 1984). For Giddens, "structure" consists of the rules and resources instantiated in a social system. Social actors index these rules and resources and thereby structure social action. Thus, social structure is both a resource for and a product of social action (Giddens, 1984:332). That is, the structural qualities which generate social action are simultaneously and continually reproduced in these actions.³

Duster (1981) has offered what we might call an "intermediate step hypothesis" as a solution to the micro-macro problem. In Duster's model neither exclusively macro nor exclusively micro considerations are tenable. Duster argues that we need intermediate steps--rungs on the ladder of abstraction--to adequately link the two theoretical levels. The bottommost rung should be empirical observations of social interaction in natural settings. The next rung should be demographic analysis which would include migration, age, sex, employment, etc. The third rung should consist of a consideration of the historical context and organizational analysis. Duster argues that the final rung might consist of "indicators" at the national level. In stressing the importance of these intermediate steps, he notes that:

³See Molotch and Boden (1985) for an empirical investigation which utilizes Giddens' theory of structuration.

A close-up of farm workers in the Central Valley of California may produce an elegant leap to world systems theory, but no matter how graceful, unless the warrant is established with intermediate connectors, the critic has an easy mark. Likewise when grand functionalists and grand Marxists alike see evidence of "the system" in every setting, both are open to effective broadsides that range from reification to tautologizing (Duster, 1981:110).

Knorr-Cetina (1981) calls her attempt to bridge the micro-macro gap the "representation hypothesis." She begins with the micro level and builds up, noting that what we consider macro level phenomena are neither the result of unintended consequences (as with Harre and Giddens) nor the result of an aggregation process (Collins). Rather, any macro phenomenon is "a summary representation actively constructed and pursued within micro situations" (Knorr-Cetina, 1981:34). Therefore, macro phenomena should no longer be explained as a "layer" of social reality; instead, we should see macro phenomena as residing in micro episodes of social interaction.

To me, these attempts are incomplete on at least two counts. First, with the possible exception of Duster's model of intermediate steps, most attempts at theoretical linkage of micro and macro see social structure as emerging from the interactional accomplishment of social reality. Rather than reifying the external world as many traditional macro sociologists have been accused of doing, most contemporary micro-linkage theorists seem to block out the external world and treat it as if it did not exist. As a sociologist and everyday member of society, it is clear to me that macro level phenomena such as social class and gender are "out

there" in the "real" world and do influence the process of social interaction. Any accurate/adequate theoretical linkage of micro and macro should reflect such an awareness.

Second, I believe that the theoretical models suffer from an incomplete treatment of the role of language in providing a basis to link micro and macro sociology. Some of philosophy's greatest thinkers--Heidegger, Gadamer, Ricour and certainly Wittgenstein--have in different ways emphasized the same general point: language allows for the possibility of "a world;" languages creates "the world;" "the world" is language. For whatever reasons, sociologists have been slow to embrace this basic philosophical wisdom. Over thirty years ago Hertzler (1953:109) called for the development of a sociology of language by drawing a very basic conclusion about the relationship between language and social reality:

One of the most distinctive characteristics of man [sic] is the fact that he is the language-inventing and language-using animal. Many of his most inimitable forms of expression, all of his objective thinking, most of his daily communication, most of his storage of culture and its transmission in space and time, almost all of his environmental adjustment, socialization, societal organization, and social action, rest upon language.

Although over the years other scholars interested in the development of a sociology of language have drawn similar conclusions (e.g., Luckmann, 1975; Fishman, 1968, 1972; Kjolseth, 1972), the study of how language functions in the social construction of reality is only slowly developing.

One model of the theoretical linkage between micro and macro sociology which does stress the fundamental importance of language is that developed by Fisher (1979, 1980, 1982, 1983), Fisher and Groce (1985), Groce and Fisher (1984) and by me in this manuscript. This model, which may be termed a "reflexive model," examines empirical situations--interviews between doctors and patients--to attempt to build a collage of intermediate steps which serve to link micro and macro considerations in the social construction of reality. By employing reflexivity we begin to see the relationship between social structure and interaction. The fundamental assumption, grounded in both philosophy and sociology, is that language is the medium through which interaction and structure produce and reproduce each other. As Fisher (forthcoming:29) has observed:

Language, at one and the same time, accomplishes [social] action and reflects, reiterates and reproduces the social order [read structure] from which it stems, reinforcing it [social order] in the process.

Even the reflexive model which I applied in the analysis of accounting practices and cultural assumptions (chapter three and four) seems incomplete without additional theoretical work. While the model does highlight language as the medium through which micro and macro phenomena reflexively constitute social reality, the theoretical question of how language functions as a medium remains unanswered. I believe that the later philosophical writings of Ludwig Wittgenstein (The Philosophical Investigations and its

preliminary drafts) provide a foundation upon which to construct a description of how language functions to integrate interaction and structure in the social construction of reality.

Wittgenstein on Language and Activity

The entire thrust of Wittgenstein's later writings, contained in The Philosophical Investigations and The Blue and Brown Books, was the relationship between language and meaning and understanding in everyday life (Malcolm, 1967; Silverman and Torode, 1980; Hekman, 1983; Thompson, 1981; Finch, 1977). While Wittgenstein never explicitly stated the relationship between his work on language and the social sciences (Hekman, 1983:2), scholars have repeatedly sought to make the connection (Finch, 1977; Winch, 1958; Giddens, 1976, 1979, 1984). Wittgenstein's thoughts on language which seem to apply most directly to sociological theory may be grouped under four general headings: meaning and use, language-games, forms of life and context (Silverman and Torode, 1980:55; Malcolm, 1967:336; Finch, 1977:21).

Wittgenstein's position on what words in a language "mean" changed over the course of his lifetime. The early Wittgenstein adopted the "logical atomist" perspective (Malcolm, 1967:330) wherein words have meaning because they are representations of objects, events, people, behaviors, etc. A one-to-one correspondence exists between a word and what it represents. Thus, "reality" is an external, objective phenomenon apart from the individuals who experience it and words create a "picture" of that reality.

Wittgenstein's thought changed dramatically in his later years. He became wholly dissatisfied with his picture theory of language, ultimately reasoning that language did not present a picture of reality at all. Instead, Wittgenstein (1953:27) posited that "the meaning of word [sentence, etc.] is its use in language." The term "use" here does not refer solely to grammar, i.e., to use "rain" as a noun or a verb (Malcolm, 1967:336; Finch, 1977:22). Rather, Wittgenstein argued that language is inextricably bound to human activity (Silverman and Torode, 1980:56). The term "use" refers to the application or employment of words or sentences (Malcolm, 1967:336)--what they accomplish when they are used. Wittgenstein's position at once frees us from two non-sociological understandings of "meaning." Meaning cannot merely be the result of representation since language does not "represent" an "external" world. Meaning also cannot be solely the result of internal psychological processes or states. Since meaning arises from language-in-use and since the use of language is tied to human behavior, the creation of meaning is logically and inescapably a social process.

The second important topic of Wittgenstein's later work concerns how language gets used in everyday life. Wittgenstein never envisioned language-use as a random process. For him, language use was highly regularized and patterned because of its affinity with human activity. To describe this regularized use of language, Wittgenstein

employed the term "language-game."⁴ It is somewhat difficult to arrive at a steadfast definition of language-games. When he first introduced the term, Wittgenstein used it in four different ways (1953:7):

I . . . will sometimes speak of a primitive language as a language-game . . . those games by means of which children learn their native language. I will call these games "language games" . . . And the process of naming stones and repeating words after someone might also be called language-games . . . I shall also call the whole, consisting of language and the actions into which it is woven, the "language-game."

An initial observation is that each of the four definitions speaks to the use of language in activity. Wittgenstein chose the term "game" in language-games to emphasize the patterned nature of language and activity. The pattern or structure of language-games is realized in the same sense that pattern and structure are seen in any other game (e.g., chess, football, etc.)--through rules, that is, games have "a certain completeness . . . a beginning an end . . . a normative character" (Finch, 1977:77; see also Giddens, 1976:44; Thompson, 1981:20). So it is with language-games--their use implies a normative framework both for the language-game itself and for the activity with which it coincides. This is evident in the language-games which Wittgenstein mentioned: describing an object, reporting an event,

⁴Finch (1977:69) argues that language-games are the "fundamental" units of sense" for the whole of Wittgenstein's later philosophy.

telling a joke, thanking and greeting (to name a few) Finch, 1977:81-82).

I have emphasized that Wittgenstein saw a definite connection between language-games and human activities. The connection is made through his concept "forms of life." Unfortunately, Wittgenstein never fully defined or explained this foundational concept. In fact, the phrase "form of life" appears but seven times in all his published work (Gier, 1980:21). Of the seven uses of the term, there appear to be four distinct interpretations (Hunter, 1968; Gier, 1980). Gier (1980:244) provides a summary of these interpretations:

- A. The Language-Game Account. In this interpretation forms of life are essentially identical with actual language-games. We can conceive of many possible language-games, but we would not necessarily find them being played in ordinary life.
- B. The Behavior-Package View. Forms of life are formalized behavior packages (e.g., certain facial expressions, gestures, acts) which are correlated with language games.
- C. The Cultural-Historical View. On this account a form of life is a way of life, or a mode, manner, fashion or style of life: that it has something important to do with the class structure, the values, the religion, the types of industry and commerce and of recreation that characterize a group of people.
- D. The Natural-History Theory, or the Organic Account. While A, B and C concentrate on the Formal dimension of form of life, this theory emphasizes the biological aspect. It is more like something typical of a living being: typical in the sense of being very broadly in the same class as the growth or nutrition of living organisms, or as the organic complexity which enables them . . . to react in complicated ways to their environment.

What we have, then, according to Finch (1977:90) are linguistic (A), psychological (B), sociological (C), and biological (D) interpretations of what Wittgenstein meant by "forms of life."⁵ While there will probably always be disagreements over what Wittgenstein "really" meant by "forms of life," a strong case can be made for the sociological interpretation (Finch, 1977: Heckman, 1983: Winch, 1958). We may think about forms of life from a sociological perspective because

human life as we live and observe it is not just a random, continuous flow, but displays recurrent patterns, regularities, characteristic ways of doing and being, of feeling and acting, of speaking and interacting. Because they are patterns, regularities, configurations, Wittgenstein calls them forms; and because they are patterns in the fabric of human existence, he calls them forms of life (Pitkin, 1973:132, emphasis in original).

Finch (1977:90) adds that sociologists should probably understand what Wittgenstein meant by forms of life better than anyone else because forms of life are roughly equivalent to "social facts" or "institutional facts." That is, forms of life are "established patterns of action shared by members of a group" (Finch, 1977:90, emphasis in original). Thus, forms of life, like language-games, display normative frameworks.

We can now begin to see the connection between forms of life and language-games. They are essentially inseparable: "To imagine

⁵See Gier (1980) for an extensive bibliography of works supporting and critiquing the four interpretations of forms of life.

a language-game means to imagine a form of life" (Wittgenstein, 1953:19). For example, take the language-game of giving and obeying orders (commands/instructions). What does this "mean?" It "means" nothing without a simultaneously occurring activity such as a battle or an educational event. Orders must be "about something." They must be grounded in some social activity--some form of life--to have meaning, to be sensible (Heckman, 1983:4). Or, as Finch (1977:91-92) has concluded:

A form of life is a possibility of meaningful action shared in by members of a group, and hence repeatable by different members of the group on different occasions and (within certain limits) in different kinds of circumstances. These are the activities which we call social or cultural and which have to be understood if we are to understand what people are doing and to make sense out of what they say (emphasis added).

The final concept which serves to integrate Wittgenstein's ideas into a sociological framework is "context" or "situation" (Finch, 1977:100-101; Altieri, 1976:1406; Silverman and Iorode, 1980:55; Heckman, 1983:4). It is the context of human activity and language or the situation in which these phenomena occur that gives them their "sense." "What stands fast [is sensible] does so, not because it is intrinsically obvious or convincing, it is rather held fast by what lies around it" (Wittgenstein, 1969:15). That is, although language-games and forms of life display underlying normative frameworks (rules), it is the framework or structure of the wider context or situation which makes the structure of language-games and forms of

life sensible (Finch, 1977:100). To play the language-game of giving and obeying orders requires a form of life such as fighting a battle which, in turn, requires a proper context. i.e., a battle-field. To give and obey orders during a battle at, say a church, would certainly change the characteristics of both the language-game and the form of life.

Taken together, Wittgenstein's notions of meaning and use, language-games, forms of life and context loom as important contributions not only to philosophy but to sociology as well. These ideas form the basis of a language-informed sociology which describes and explains the interconnections of micro and macro social phenomena. In the next section, I will briefly review and critique an important attempt at creating a Wittgensteinian sociology. I will then move to my view of how Wittgenstein's ideas may be applied fruitfully to the study of the social construction of reality.

Winch's Application of Wittgenstein

Winch (1958) has attempted the most comprehensive sociological application of Wittgenstein's philosophy to date (Turner, 1980:3; Giddens, 1976:44). While Winch's model has not received widespread critical acclaim in the United States, it remains something of an "underground classic" in European sociology.⁶ Winch's starting point

⁶Personal communication, Professor Donald A. Clelland, Department of Sociology, University of Tennessee, Knoxville, TN, , January 7, 1986.

is Wittgenstein's observation that both language and human activity are rule-governed (Finch, 1977:99; Turner, 1980:6). Winch expands the notion of rule to include all types of "conventional" behavior. He bases "social meaning" in rule following and concludes that "all behavior which is meaningful (therefore all specifically human behavior) is ipso-facto rule-governed" (Winch, 1958:52, emphasis in original). When Winch argues that all meaningful behavior is ipso-facto rule-governed, he means that

In order for an act to mean a particular thing to a particular agent--to be an act of a particular kind of him [sic]--it must be governed by a rule, minimally, the rule that identifies the act as meaning that particular thing and not another, or identifies it as an act of that particular kind and not another (Turner, 1980:12).

Winch's application of Wittgenstein's philosophy includes a heavy emphasis on the "form of life" concept (Giddens, 1976:48). He argues that meaningful human behavior is rule-governed simply because forms of life contain a normative structure (read "rule-structure"). Presumably during the socialization process individuals internalize the rule-structures of a myriad of forms of life. Thus, to say that behavior is rule-governed is to say that forms of life are rule-governed.

Winch's Wittgensteinian explanation of human behavior has met with strong objection (Turner, 1980; Giddens, 1976). The bulk of criticism focuses on Winch's interpretation and application of "rules." Giddens (1976:47-48) has observed that

[T]he notion of "rule" does too much work in Winch's discussion, and is not adequately explicated. According to him, we can show whether any given mode of behavior is rule-governed, and thereby "meaningful," by reference to whether or not it makes sense to say that there is a "right" and a "wrong" way of doing it.

Problems arise when we consider activities such as washing one's face. We may certainly agree that this activity constitutes "meaningful" behavior. The way in which the notion of rules applies to this activity is more problematic. Winch would say that washing one's face constitutes rule-governed behavior simply because we have a normative framework within which certain versions of face-washing are appropriate while others are not (i.e., washing one's face with soap and water as opposed to cow manure). But, as Giddens (1976:48) observes, this is both a restrictive and un-Wittgensteinian understanding of rules. As Wittgenstein took such pains to explain, human behavior occurs through forms of life and language-games--not just the former. Thus, in addition to the rules constituting forms of life, we must also consider the linguistic rules of language-games. Not only is it inappropriate (a deviation from the normative structure or the breaking of a rule) to wash one's face with cow manure, but it is also inappropriate to say, "I am now washing my face," as I spread soap and water across my chest.

Another important criticism made by Giddens (1976, 1979, 1984) and others is that Winch's application of Wittgenstein fails to address the influence of power, authority and domination in forms of life and language-games. That is, when Winch claims that all

meaningful human behavior is rule-governed, his explanation never considers whose rules people are following. Language and language-use between people in social situations are not symmetrical phenomena; rather, language

expresses asymmetries of power; and it is impossible not to accept that social norms . . . are frequently imposed as obligations within systems of domination (Giddins, 1976: 48, emphasis in original).

I have attempted to outline: (1) those elements of Wittgenstein's later philosophy which might inform a language-based sociological theory; (2) Winch's application of Wittgenstein in his rule-structure model of human behavior; and (3) the criticisms of Winch's model which suggest that much work is left to do in organizing a truly Wittgensteinian sociological theory. In the following sections I should like to suggest: (1) how we may improve on Winch's use of Wittgenstein to build a sociological theory which integrates micro and macro social phenomena; and (2) how such a theoretical model may be fruitfully applied to the study of how doctors and patients socially construct the realities of medical interviews and outcomes.

Toward a Wittgensteinian Sociological Theory

A proper beginning point for a sociological theory which incorporates Wittgenstein's later philosophy is the concept "rule." We may employ the dictionary definition of rule: a principle of conduct observed by members of a group. This definition serves two purposes:

(1) it links the notion of rules with human social behavior, (2) which, in turn, links rules to some normative framework. That is to say that an individual who follows rules of group conduct necessarily links him/herself to some set of social norms. Indeed, in some definitions "rule" and "norm" become synonymous. Theodorson and Theodorson (1969:276-277) define social norm as

A rule or standard of behavior defined by shared expectations of two or more people regarding what behavior is to be considered acceptable. Social norms provide guidelines to the range of behavior appropriate and applicable to particular social situations.

In short, rules (norms) exist "if most people note and disapprove" of their breaking (Argyle, et al., 1981:7)⁷

As previously mentioned, part of Winch's problem with his application of Wittgenstein was his failure to acknowledge different levels or types of rules. I have already mentioned Giddens' suggestion of "linguistic rules" as distinct from other behavioral rules. We should also consider Harre's (1974:163) distinction between constitutive rules and strategic rules.⁸ Constitutive rules are the norms which define appropriate behavior in particular situations--such as going to work each morning fully clothed. Strategic rules are different in that they assist individuals in "winning" in certain

⁷For anthropological and philosophical treatments of rules, see Douglas (1977).

⁸The original discussion of constitutive rules in language was made by Searle (1969).

situations or attaining one's goals (such as an individual appearing to be quite busy whenever his/her boss walks by). Or as Morris (1956:612) has observed, we may make a distinction between absolute and conditional norms--norms (rules) which vary on a continuum based on greater or lesser degrees of extent of knowledge of norm, extent of acceptance, degree of sanction, source of authority and method of transmission.⁹

The relationship between linguistic, constructive and strategic rules becomes clearer when we consider the relationship between Wittgenstein's major concepts of meaning/use, language-games, forms of life and situations (context). First, Wittgenstein argued that "meaning" is created through language-use. We do not randomly employ language in the everyday construction of social reality. Rather, we use language in accordance with a normative framework--language is "meaning" through its use within a rule-structure. Rules also apply to Wittgenstein's notion of language-games. Language-games are the rule-bound linguistic patterns through which we communicate. We can see the importance of both constitutive and strategic rules in language-games. Questions and answers stand as primary language-games. Their form achieves structure from the constitutive rules of turn-taking. The way in which individuals employ questions and answers on

⁹Morris's typology of norms was offered as an improvement on and extension of the earlier classification systems of Summer, Linton, Sorokin and Williams. He argues that norms may be classified along four fundamental dimensions: (1) distribution of norms; (2) enforcement of norms; (3) transmission of norms; and (4) conformity to norms.

various occasions and in various contexts is determined by strategic rules (such as repeatedly asking a question or failing to provide an answer to a question).

Rules are also important for forms of life. Specifically, it is constitutive rules that give human activities (forms of life) their patterning or structure. For instance, we have constitutive normative frameworks which inform us of the basic rules for "giving a party," "going shopping," "getting a college education," and the like. It is important, too, to see the relationship between rules, language-games and forms of life. Take, for example, the human social activity of "giving a party." This activity may have numerous attendant language-games, some of which are based primarily on constitutive rules (such as greeting guests as they arrive and bidding them farewell as they depart) and other strategic rules--such as talking primarily with guests who may be in a position to further your career.

Context is also an important consideration when we examine the relationship between language, activity and rules. Consider the context (situation, setting) of a grocery store. A number of forms of life, each with constitutive rules, are present at a given time: shopping for groceries, paying for them, managing a business, delivering food to a store, etc. Each form of life (activity) may have a number of possible language-games, each with constitutive and strategic rules (formulating "place," i.e., directions for locating items on a shelf, arguing about grocery prices, trying to get the store manager to approve a personal check, etc.). Every situation may

contain (allow for) numerous forms of life and language-games, but it is always the situation which gives the appropriate form of life and language-games their "sense" (meaning).

We may use rules, language-games, forms of life and context to begin to build a theoretical framework which links micro and macro levels of sociological analysis. To begin with, consider the normative structure of language and activity--in our current terminology, their constitutive and strategic rules. Figure 1 shows how this relationship may be represented.

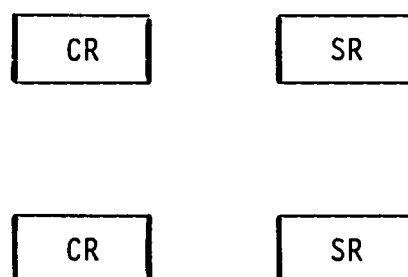


Figure 1. Language-Games

Where "CR" is a constitutive rule and "SR" is a strategic rule, every conceivable language-game is a combination of these two types of rules. We also know from the previous discussion that language is connected to human activity. Thus, we may envision the relationship between forms of life and language-games as shown in Figure 2.

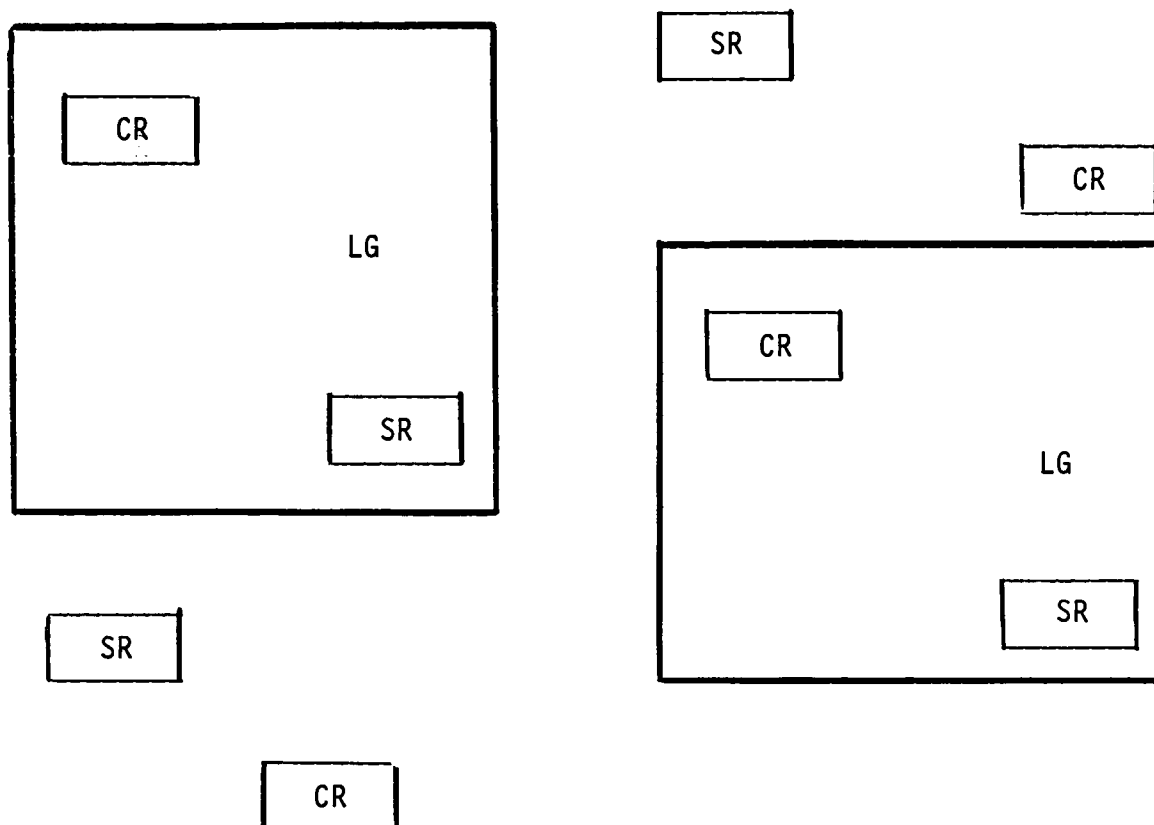


Figure 2. Form of Life

Each patterned, normative human activity--form of life--may contain numerous language-games. We said before that language-games are made up of rules. So, too, are forms of life. In addition to rules of language-games, forms of life also contain their own constitutive and strategic rules which are not part of the attendant language-games.

The next step is to see the relationship between language, activity and context. This relationship may be represented in the manner shown in Figure 3. Every situation (setting, context--broadly defined) allows for a number of possible forms of life, language-games, constitutive and strategic rules.

We are now in a position to link micro and macro levels of sociological analysis. Based on Figures 1 and 2, we can argue that language is the medium which reflexively links micro and macro. On the one hand, situations do not exist without human activity; human activity does not exist without use, which we know from Wittgenstein implies both activity (form of life) and context (social, cultural). Thus, when individuals talk to each other they not only "talk social interaction," but they also "talk social structure" (Molotch and Boden, 1985; Fisher and Groce, 1986). They bring with them social and cultural "facts"--gender discrimination, social class and racial differences, institutional authority and the like. These social and cultural "facts" do not merely fall from the sky to become part of an "objective reality," but rather they were forged from particular configurations of forms of life, language-games

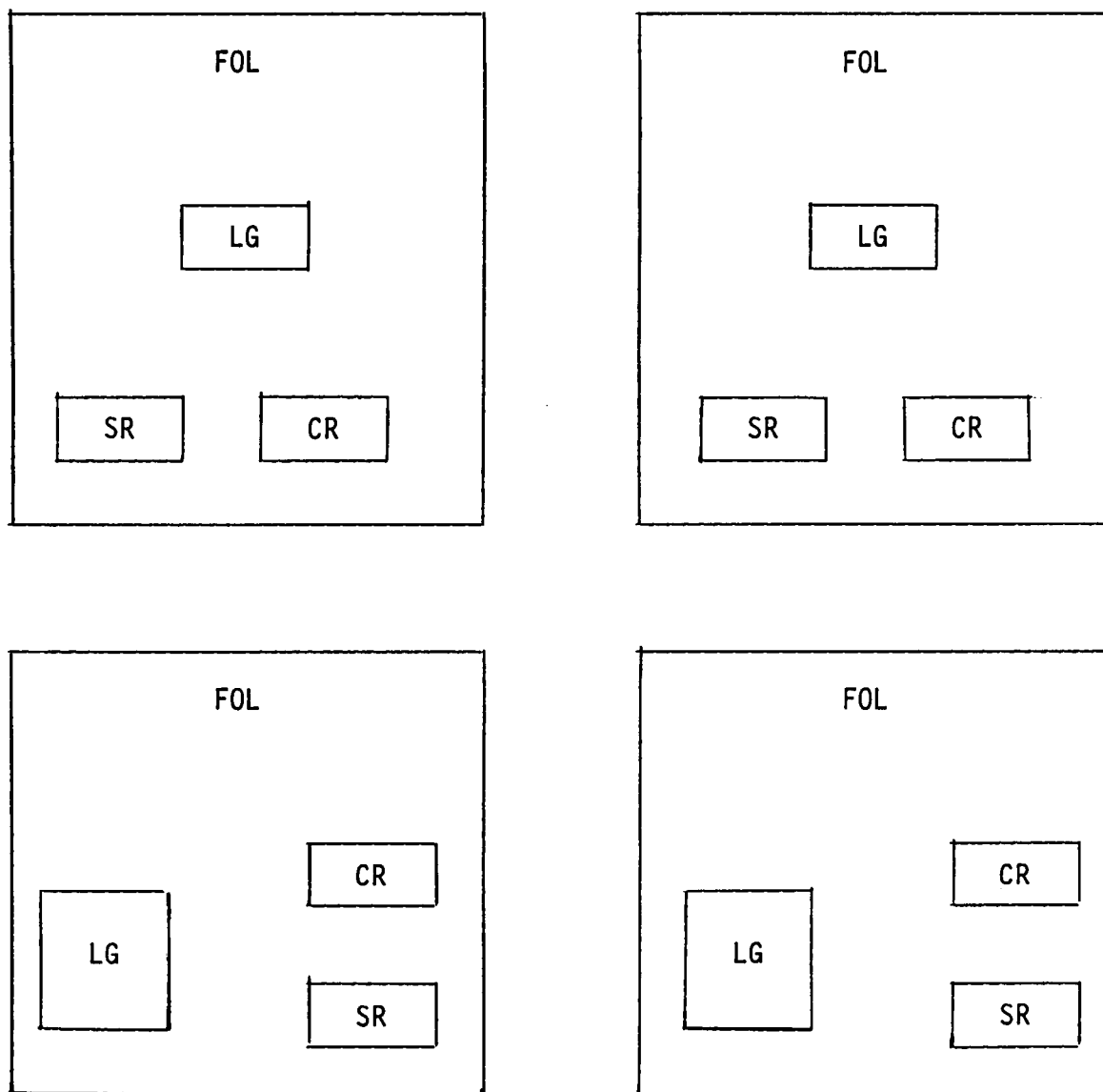


Figure 3. Situation, Setting, Context

and situations of previous social actors. Though we may continually modify and alter both forms of life and language-games, we are nevertheless influenced (through the socialization process) by vestiges of language-use in other times and in other places. When we interact, then, we use language to support and reproduce an existing social structure. In essence, to paraphrase Heidegger, to talk is to create the world. We create it moment by moment. We also reflexively create it on two supposedly distinct levels, the interactional and the structural, simultaneously. We may now see Wittgenstein's ultimate value to sociology. From his point of view, to talk--to use language in connection with human activity--is to necessarily both interact and structure.

The preceding stands as a brief outline of a theoretical model. In the following section I will attempt to apply it to some of the findings presented in Chapters III and IV. My goal is to show how we can see doctor-patient communication as both a micro and a macro accomplishment.

Linking Micro and Macro in the Medical Setting

Just as sociologists have argued about the nature of the social world and appropriate levels of theoretical analysis, medical sociologists have argued about the nature of the medical world. As Mishler (1981:83-101) has observed, medical sociological work may be divided into three general classifications: macrocontext, mesocontext and microcontext. The macrocontext represents a

structural level of analysis. At this level, some researchers stress the norms which govern the medical relationship--for example, Parsons' (1954) discussion of the "sick role." With the doctor acting as an agent of social control, the sick role is functional both for the social system and for the sick individual. Another body of work at this level employs structural indicators to describe illness behavior. For example, Mechanic (1972) has examined the demographic correlates of disease, the decision to seek medical treatment and responses to treatment. Others, such as Zola (1980) focus on how structural factors influence medical outcomes such as patients' compliance with medical regimens.

Work at the structural level shares a common assumption, namely, that societal arrangements can be used to account for the nature of the relationship between doctors and patients. Most of this research emphasizes the functional nature of the medical system and medical relationships. While also emphasizing societal arrangements, work such as Navarro's (1976) analysis demonstrates that patterns of dominance at the societal level are mirrored in the organization and delivery of health care. In Waitzkin and Waterman's (1974) analysis of exploitation in the health care field, patients closely parallel and proletariat in classical Marxian analysis. They argue that under a capitalist economic structure, illness is a source of profit and power "for the medical profession, for corporations which produce drugs and equipment and for hospitals and other organizations which provide health care" (Waitzkin and Waterman, 1974:7).

A second body of literature deals with the mesocontext or how the organization of the medical profession and the practice of medicine influence the doctor-patient relationship. Freidson (1970) argues that features of the medical profession such as a high level of autonomy (the freedom to operate largely without outside regulation), control over licensure, the process of medical education and the social organization of the practice of medicine (fee-for-service, group practice, etc.) have consequences for both the doctor-patient relationship and illness behavior. Freidson also claims that there is a discrepancy between the normative expectations within the profession of medicine and actual medical practice. He argues that it is hard to reconcile the "service orientation" (part of the ideology of professionalism) with the reality of doctors who charge high fees for their services and their apparent unwillingness to practice in low-income areas of the country. Other important mesocontextual variables include hospital size and staff-patient ratios (Moos, 1974) and hospital stratification systems (Mishler and Tropp, 1956).

A third body of literature examines medical interactions (the microcontext). It focuses on the doctor-patient relationship as a social construction. Some researchers have investigated how patients socially construct reality, for example, Davis' (1963) study of polio victims, Roth's (1963) analysis of how tuberculosis patients organize social time and Luker's (1975) study on women's decisions to abort pregnancies. Others focus on how doctors, as social actors, construct meaning. Examples include Bosk's (1979) and Millman's

(1977) work on the social construction of medical errors and Scully's (1980) work on the training of obstetricians and gynecologists. Still other researchers have chosen to focus specifically on communication between doctors and patients, employing a sociolinguistic orientation (e.g., Shuy, 1983; Tannen and Wallat, 1983), conversation analysis to look at the structure of medical discourse as a socially accomplished event and to find rules to explain it (e.g., Frankel, 1983; West, 1983), or discourse analysis models to examine the interactional accomplishments of medical outcomes which are embedded in socio-political contexts (e.g., Fisher and Todd, 1983; Fisher and Groce, 1985, 1986).

The distinctions between macrocontextual, mesocontextual and microcontextual analyses in medical sociology are arbitrary and misleading. By treating language from a Wittgenstinian perspective and realizing that language is the medium through which micro and macro phenomena are reflexively linked, we may arrive at a conclusion similar to Cicourel's (1981:71):

. . . the physician-patient interview and medical history can be viewed as routine examples of continual micro-macro integration which combines several levels of complexity. The substantive content of the discourse becomes the vehicle for tracing the ways in which micro-events are transformed into macro-structure.

That is, we have no need to speak of structural, organizational and interactional levels of analysis. All medical sociological phenomena are contained in and produced by the language and activities of social actors within the medical setting.

At this pointed, I would like to re-interpret some of the findings from Chapters III and IV in light of the rules/language-games/forms of life framework. Such an exercise will allow us to better understand how doctors and patients integrate micro and macro phenomena in the social construction of medical interviews and treatment decisions. Consider the medical interview as a form of life which takes place within a particular context (in this case, a family practice clinic). Medical interviews contain numerous language-games. The most primary of these language-games is probably the "question-answer" game. Questions and answers exhibit both constitutive and strategic rules. The grammatical and syntactical form of questions and answers displays constitutive rule-following. Strategic rule-following is apparent in the interactional use of questions and answers. When doctors and patients ask and answer questions in the appropriate places (or fail to do so), they contribute to the goal of reaching a treatment decision. Their appropriate or inappropriate use of questions and answers is also strategic in the sense of "identity work"--the pictures of themselves they build for each other over the course of the medical interview.

The medical interview is also made up of other language-games. We may look at the various phases of the interview as language-games. We may speak of the "opening language-game," the "medical history language-game," the "physical examination language-game" and the "closing language-game." Again, each phase's language-game exhibits both constitutive and strategic rules. When a patient provides

medical history information during the medical history phase, she/he has followed a constitutive rule. Doctors and patients also follow strategic rules in each phase by working together to produce a satisfactory treatment decision.

We may take the analysis of accounts and accounting practices presented in Chapter III and interpret it from the language-game perspective. Accounts are a ubiquitous feature of social interaction. They stand as a primary language-game which cuts across many forms of life. Actually, we could say that the phenomenon of accounts contains two language-games--the giving of accounts and the response to accounts. Consider the following example:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: what did it feel like	P: whew well it's hard to explain how it felt it just//	
D: //was it chest pain	P: right uh I had a hard time breathing of course you//	
D: //is that recently or do you always have a hard time breathing . . . why didn't you come to the hospital what you're describing to me are symptoms of a heart attack	P: right	
D: is that what you expected	P: yeah	
D: why didn't you come to the hospital	P: 'cause if I went to the hospital	

they I know my
system and I know
what I can do
with it and uh last
time I had one they
put me in the
hospital I like not
to got out

(#35, p. 2)

A number of language-games are operating here. Doctor and patient are participating in a question-answer language-game. They are also creating the opening phase of the interview through its language-game. Further, the interactants are playing an accounting language-game. The doctor follows both constitutive and strategic rules in requesting an account from the patient: he makes his request in the appropriate grammatical and syntactical form (constitutive); he also asks the question twice--suggesting its strategic use in the information-gathering process. Likewise, the patient's account (in terms of both structure and process) fulfills the constitutive and strategic rules of the language game.

In the following example, we begin to see what the language-game analysis of accounts can tell us about micro-macro linkage in the social construction of medical interviews:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: I'm Dr. _____ why why don't you go ahead and sit up there what can I do for you today	P: well I got a bad ear problem	
D: you do	P: I do and in my profession I can't afford it	

D: tell me about it P: well Sunday it
 started hurting// D: //uhhuh
 Monday it is this
 ear here got sore
 so sore I could'nt
 touch it D: oh really

(#22, p. 1)

Doctor and patient are participating in the "opening language-game" of the medical interview. The patient volunteers an appeal to higher interests account: because of the nature of his occupation, he cannot afford to have ear problems. In volunteering the account, the patient apparently follows the constitutive rules of account-giving. Using proper grammar and syntax he has produced an account that is intelligible to us as readers and so apparently intelligible to the doctor as a hearer. Yet, the doctor's response to this account is an "ignore," or a non-response. He proceeds as if the patient had never volunteered the account. I suggest that the doctor's non-response displays two related features of the interaction: (1) the doctor has exercised the institutional authority of his role to keep the conversation on what he apparently considers a medically relevant topic; and (2) he is able to do this because the authority difference inherent in the context of doctor-patient interaction has changed the strategic rules of the accounting language-game. Even though from the patient's point of view the account does follow strategic rules (i.e., showing the doctor the significance of the ear problem on the patient's life), to the doctor this account violates the strategic rules of accounting because it interferes

with the transmission of medically-relevant information--and it is the doctor's definition of relevance which stands.

We may use the language-game analysis to re-interpret the analysis of cultural assumptions presented in Chapter IV. Consider the following excerpt:

<u>Initiation</u>	<u>Response</u>	<u>Comment</u>
D: what's going on with you today	P: well I well I work yesterday//and the D: //uhhuh Red Cross came down on the job they checked all the working/ people and I wasn't hurting I was feeling good and they said mine was 210	
D: your your//	P: //blood was 210 yesterday	
D: what was 210	P: my high//	
D: //your blood pressure	P: yeah and then uh I went to I went to the health department and they registered 226	
D: that's pretty high	P: yeah	
D: have you ever had that problem before	P: no I didn't know it but they came down I didn't know I had no blood pressure	
D: when was the last time you'd had your blood pressure		

checked before
yesterday

P: uh well that's a
long time I didn't
know I had it
because when they
came down there
they just came on
the job

D: how old are you

P: forty-four

D: forty-four

D: how often do you
get your blood
pressure checked

P: well that's the
first time I ever
got it checked

D: first time you ever
had it checked

P: yeah

D: you ever been seen
by a doctor

P: uhhuh//I've been
you know I've been
to the doctor
before but I didn't
get no blood
pressure

D: //uhhuh

D: they never checked
your blood pressure

P: no

D: when was the last
time you was seen
by a doctor

P: well when they
catheterized me

Notice the difficult time the doctor has communicating with the patient. As I noted before, the combined influence of the patient's grammar, syntax and lack of referents make his articulation of his medical problem difficult to understand. This amounts to a violation of the constitutive rules of the language-game for opening medical interviews. In failing to follow constitutive rules, the patient has, at the same time, neglected the strategic rules of the language-

game. He has presented neither himself nor his medical information in such a way as to facilitate the medical interview.

The importance of the doctor's code-switching ("When was the last time you was seen by a doctor?") takes on added significance when we consider it within the language-game framework. In a sense, the doctor violates both constitutive and strategic rules by code-switching. He has altered the language-game currently in use. But what he has also done by code-switching is to bring both a new form of life and a new language-game into play. Not only is he participating in the medical interview form of life, he is now participating in the form of life we might call "treating others as social inferiors." This form of life carries with it any number of language-games, and the one currently displayed is a code-switching game.

We are now in a better position to understand this doctor's treatment (or lack of it) of this patient. Recall that the patient left the clinic with none of his medical problems adequately investigated or addressed. Now we may see that this was because there was more than a neutral medical interview going on. The language which passed between doctor and patient actualized another activity (form of life)--negative stereotyping. This additional form of life (and its attendant language-games) had some very serious consequences for the social reality constructed by this doctor and patient.

This attempt to theoretically apply Wittgenstein's language-game framework to the analysis of medical interviews has been brief but

important. By considering language-use, language-games, forms of life and context, we may begin to truly see how macro and micro phenomena are linked through language. To focus solely on the minutiae of social interaction is to become oblivious to the influence of structural-level variables such as race, gender, social class and institutional authority; to even begin to talk about these macro-level concerns without first examining what people say to each other is just as pointless. The supposed polar opposites, micro and macro, do not exist independently of one another. Perhaps a more important observation is that they do not exist independently of the language social actors employ in various situations. Morris (1956:613) speculated on the sociological value of studying normative frameworks. He called for research into the relationship of norms to what he called other "outside factors." He also noted that research might uncover social actors' perceptions of the characteristics of absolute (constitutive) and conditional (strategic) norms. The preceding discussion has been an attempt to address the concerns voiced by Morris as well as an attempt to go beyond them. The theoretical analysis presented here is not just another reformulation of a traditional normative explanation of social behavior. I am suggesting much more than the idea that actors create norms which, in turn, inform and govern behavior. I have tried to show how interactants actually use social norms and how these norms (rules) are at the same time both interactional and structural.

These paragraphs have been an initial attempt to radically alter the way we approach the analysis of social reality. What we perceived (and seek to study) as micro-level or macro-level reality is nothing more than the continual intersecting, through language, of forms of life and language-games, constitutive and strategic rules within social contexts. If we better understand the nature of forms of life and language-games and how we subtly slip in and out of them as we interact, then we should be better able to understand two things: (1) specifically, how doctors and patients create medical interviews and treatment decisions; and (2) generally, how social reality is constructed through language. It may be that such an approach is exactly what we need (to paraphrase Wittgenstein) to lead the sociological fly out of the bottle.

APPENDIX II

DISTRIBUTION OF INTERVIEWS ACROSS FAMILY PRACTICE RESIDENTS

<u>Resident</u>	<u>Interview</u>
#1	#17, #35, #39
#2	#4, #10
#3	#8, #12, #14, #37, #43
#4	#6, #9, #19, #22
#5	#25, #28, #31, #36
#6	#16, #23, #24, #29, #30
#7	#20, #41
#8	#3, #11, #32, #38
#9	-----
#10	#5, #40, #42
#11	#27
#12	#13, #15, #34
#13	#1
#14	#2
#15	#7, #18, #21, #26, #33

APPENDIX III

TRANSCRIPTION NOTATIONS
(Adapted from Jefferson, 1972)

1. Interruptions and insertions--represented by "//." If "//" appears at the end of an utterance it denotes the point at which speaker B interrupted speaker A. If it occurs at some point during an utterance it denotes the point at which speaker B inserts a comment (such as "uhhuh," "right," or "yeah").
2. Unintelligible utterance--represented by (). This symbol means that the analyst, due to excessive background noise, swallowed words or tape hiss, was unable to understand what one or more speakers were saying. If the parentheses contain a word or a phrase, that word or phrase is the analyst's best guess as to what the speaker(s) said given what was audible.
3. Omitted utterances by a single speaker--represented by ". . ."
utterances made by the same speaker.
4. Omitted utterances by more than one speaker--represented by vertical ellipses: .
.
.

This symbol means that an exchange between the two speakers is being reported in part.

5. Pauses in conversation--represented by parentheses containing whole and tenths of seconds. For example (5.0) means that a five second pause occurred between two words, phrases or utterances.

APPENDIX IV

PATIENTS' DEMOGRAPHIC INFORMATION

<u>Patient #</u>	<u>Race</u>	<u>Age</u>	<u>Education</u>	<u>Occupation</u>	<u>Income</u>
1	C	28	college	custodian	-----
2	C	33	8th gr.	brick layer	<\$ 5,000
3	C	35	college	artist	>\$25,000
4	C	29	college	park ranger	-----
5	C	29	grad. sch.	professor	-----
6	C	43	grad. sch.	administrator	-----
7	C	33	college	librarian	-----
8	C	54	college	administrator	-----
9	C	44	h.s.	TV technician	-----
10	C	21	h.s.	unemployed	-----
11	C	25	college	bartender	-----
12	C	22	h.s.	cook	-----
13	C	30	-----	mechanic	-----
14	C	20	-----	electrician	-----
15	C	46	college	h.s. teacher	-----
16	C	45	grad. sch.	professor	-----
17	C	55	grad. sch.	professor	-----
18	C	21	college	student	-----
19	C	21	h.s.	student	-----
20	C	23	h.s.	maintenance	-----
21	N	72	8th gr.	taxi driver	\$8,000- 12,000
22	C	25	11th gr.	musician	<\$ 5,000
23	C	24	h.s.	technician	\$18,000- 21,000
24	C	45	college	administrator	-----
25	C	22	college	security guard	-----
26	C	41	grad. sch.	unemployed	-----
27	C	34	college	student	-----
28	C	24	h.s.	-----	<\$ 5,000
29	C	34	-----	computer tech.	-----
30	C	59	h.s.	retired	-----
31	C	35	grad. sch.	veterinarian	-----
32	C	40	grad. sch.	professor	-----
33	C	31	college	contractor	-----
34	C	25	college	student	-----
35	C	50	2 yrs. col.	unemployed	-----
36	C	35	college	geologist	-----
37	N	44	10th gr.	construction	\$8,000- 12,000

<u>Patient #</u>	<u>Race</u>	<u>Age</u>	<u>Education</u>	<u>Occupation</u>	<u>Income</u>
38	C	22	h.s.	floor refinisher	-----
39	C	21	2 yrs. col.	technician	-----
40	N	58	9th gr.	custodian	-----
41	C	70	-----	retired	-----
42	C	48	h.s.	construction	-----
43	C	25	h.s.	fabric cutter	\$8,000- 12,000

VITA

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