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PROCESSES OF COMMUNICATION BETWEEN DOCTOR AND PATIENT

by

Thelma Jean Skinner

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

Doctor of Philosophy

Thesis Director's Signature:

Houston, Texas

May, 1974
ACKNOWLEDGEMENTS

I am grateful to the following sources of aid and comfort:

Dr. Carlos Vallbona opened the doors for the project.

The Southwest Center for Urban Research and the National Science
Foundation generously agreed to fund the project.

The doctors, patients, and staff at the public health clinics
allowed me into their world for a time.

Dr. Kenneth Leiter gave me the benefits of his inventive mind,
guiding, instructing, correcting, cajoling me into doing far
better work than I could have done without him.

Dr. William C. Martin improved the style of my written words
and challenged me with his critical (but friendly) views.

Dr. Steve Tyler provided an awesome number of insights—valuable
for my work, invaluable for my life.

Dr. Edward Norbeck gave me hope.

My children stayed friends with me.

My husband supported me with his unfailing good spirits, percep-
tive advice, and long-suffering love. All that is of value in
this work, I dedicate to him.
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CHAPTER ONE

INTRODUCTION

The investigation reported in these pages attempts to elucidate the processes of communication between doctors and patients. Primary interest centers on how doctors and patients come to understand one another, what procedures doctors follow in formulating diagnoses, and how both doctors and patients establish the warrantability of what has passed between them. These are the issues that will be addressed in subsequent chapters. The aim of this introductory chapter is to present the bases for examining such issues. To this end, I will make the following argument. The interaction between doctor and patient holds a crucial place in the overall therapeutic endeavor. Because of its centrality, any problem in communication that arises during the interaction can have a deleterious effect on the well-being of the patient. Major investigations that have focused on these problems have left some key questions unresolved because they have not adequately addressed an important and logically prior issue, i.e. the essential nature of the communicative process. I will propose that this inadequacy results from the theoretical perspective adopted by former investigators and then outline an alternative perspective that will allow the communicative process itself to become the topic of study.
The Crucial Role of the Interaction Between Doctor and Patient

One of the fundamental transformations in modern medicine has been termed the "deterioration" of the relationship between doctors and patients (Kemper, et al., 1971:245-46). Due to high mobility in the population, a physician does not know his patients over an extended period and has little chance to become cognizant of significant aspects of the settings in which they live. Moreover, technical advances within the medical field itself, such as electronic methods of analysis, have resulted in a dependence on laboratories and skilled technicians so that the former pattern of close contact between doctor and patient is impossible to maintain (Parsons, 1963:21-24). Advances in physiochemical medicine and cybernetics have increased specialization and contributed to the production of medical care frequently characterized as dehumanized and compartmentalized (Cleghorn, et al., 1971).

These changes notwithstanding, the interaction between doctor and patient—however brief or circumscribed—still holds a crucial place in the therapeutic endeavor. It is here that symptoms are discerned, diagnoses formulated, and treatment begun. In the following paragraphs, each of these aspects will be discussed.

Many patients know little more about their illness than that they do not feel well. It becomes the doctor's task, then, to help the patient actually discover his symptoms. Throughout his interaction with the patient, he attends to visible, audible, and palpable clues to pathology, though neither he nor the patient knows in advance which clue will carry the significant information about disease. Ostwald describes
this process of ascertaining symptoms and formulating a diagnosis as follows:

Diagnosis is a form of pattern recognition. It starts with symptoms and signs (messages) that are interpreted according to certain rules about syndromes (concepts) of disease. . . . Interpretation of signs and symptoms is akin to the breaking and deciphering of intricate code systems (1968:95).

On the basis of the sense he has made of the evidence before him, the doctor prescribes a course of treatment. Here again the crucial place of the relationship between the doctor and patient becomes apparent. Patients who regard the interaction as satisfactory are likely to comply with doctor's instructions; those who are dissatisfied frequently ignore the prescribed regimen. In a study by Milton Davis (1968) conducted at a general medical clinic of a large hospital, a third of the total group of patients was found to disregard the doctor's advice. Davis reports that failure to adhere to medical recommendations was related to deviant communication between doctor and patient, difficulties in communication, and attempts by doctor and patient to control one another. Visits between an authoritative patient and a passive doctor helped promote noncompliance on the part of the patient. Noncompliance was also likely when tensions in the relationship occurred but went unrelieved. And finally, noncompliance was likely when doctors asked the patients for information but gave no direct response to their reply.

The importance of the interaction between doctor and patient rests not only on its role in establishing a diagnosis and in gaining the cooperation of the patient but also on its role as part of the treatment. A substantial body of research suggests that the doctor
himself has a healing influence on his patient due to his position of authority and powers of suggestion. The study of such influences has been designated as the study of the placebo effect. The word "placebo" has been defined by Shapiro as the

... psychological, physiological or psychophysiological effect of any medication or procedure given with therapeutic intent, which is independent of or minimally related to the pharmacologic effects of the medication or to the specific effects of the procedure, and which operates through a psychological mechanism (1959:299).

On the basis of his review of medicine through the years, Shapiro concludes that

... the history of medical treatment for the most part until relatively recently is the history of the placebo effect, since almost all medications until recently were placebos (1959:301).

In recent years, numerous papers have documented the importance of the doctor's personal influence on his patient in the treatment of almost every disease (Bloom, 1963; Honigfeld, 1964a, 1964b; Liberman, 1962). The nature of the relationship between the doctor and patient is reported to affect not only the emotional responses to disease, but also the physiological (Wolf, 1959).

The interaction between the doctor and his patient, then, plays a significant role throughout the procedures of detecting symptoms, arriving at a diagnosis, and securing the cooperation of the patient, as well as in the healing process itself. Because of its central place in the course of treatment, any problems in communication that arise between the doctor and patient can have a critical effect on the chances of therapeutic success. Attempts to explore these problems, their sources and consequences, have been reported by several researchers and
we turn now to a review of these investigations.

Research into Problems in Communication
Between Doctor and Patient

Some investigators report that serious difficulties in communication arise in the interaction due to competing efforts on the part of the doctor and patient to deal with the stressful situation produced by illness. Searles (1952), for example, sees the active striving to cope with anxiety as frequently but inadvertently resulting in states of confusion, perplexity, and suspicion. Jacobs (1971), however, lays most of the blame for these states on the doctors' inept handling of the transfer of information. He interviewed mothers of retarded children regarding their experience at a specialized clinic and found their general consensus to be that their interactions with the doctors were unsatisfactory. Jacobs states:

... notwithstanding the physician's tendency to attribute unsatisfactory encounters between himself and the parents to the parents' unconscious defense mechanisms, e.g. "blocking," "distorting," "projecting," the doctor was responsible for much of the untoward feelings that were generated during these encounters (1971:156).

The ways the doctors contributed to these negative outcomes took one or more of the following five forms. 1) Doctors disagreed with one another about the diagnosis. 2) The doctor's diagnosis proved to be inaccurate and, as a consequence, the parents felt they could no longer take seriously the professional evaluation of their child. 3) The parents learned that information relevant to the diagnosis, or even the diagnosis itself, was withheld from them. 4) A diagnosis was not adequately explained so that parents were left to interpret the child's status on
their own. 5) The doctor, though certain of the diagnosis of mental retardation, was uncertain of its origins. The parents then faced an ambiguous situation that provided for both hope and frustration.

On the basis of these findings, Jacobs holds that perplexity, confusion, and suspicion on the part of the patient may be a manifestation of defensiveness, but not as often as the doctor thinks. In fact, he contends that frequently the doctor's effort to invoke this explanation is itself a defense mechanism. The basic fault, according to Jacobs, lies in the fact that doctors are not taught enough strategies for dealing with the "non-medical" problems of communication and counseling during stress. This situation is deplorable because, as Jacobs points out, the way medical information is passed on to the patients has a direct bearing on their health and well-being (Jacobs, 1971:156).

Studies attempting to pinpoint further the source of the misunderstanding in the communication between doctor and patient often focus on the fact that the doctor and patient are working with different vocabularies and different stores of knowledge. In an investigation by Pratt, Seligman, and Reader (1957), two hundred and fourteen patients at the clinic of a large metropolitan medical center were queried about the etiology, symptoms, and treatment of ten common diseases. In addition, fifty new patients were questioned on arrival at the clinic about the condition they suspected they had. Doctors at the clinic answered a questionnaire aimed at determining how much information they thought their patients knew. It was found that patients were poorly informed about their own condition when they first visited the clinic and about the ten common diseases. The physicians did not accurately judge the
level of medical knowledge of their patients. Despite the low level of
knowledge among patients, the doctors rather consistently underestimated
the level. Those whose underestimation was greatest were found least
likely to discuss the illness at any length with the patient.

In a similar vein, Plaja, Cohen, and Samora (1968) asked patients
in three clinics to define a list of ten medical terms commonly used by
the doctors. They found the level of knowledge to be rather high and
that both patients and doctors tended to perceive few serious barriers
to their ability to understand each other at a verbal "denotative" level.
The authors explained their findings by suggesting that the personnel in
the clinics expected their patients to be ignorant of medical terms and
took pains to re-word and clarify. The authors also noted that, though
the doctors made efforts to have the patients understand the general
topic under discussion (e.g., menstruation), they often failed to main-
tain these same efforts during attempts to elicit the more specific
elements necessary to diagnosis (e.g., menstrual regularity).

Finally, Korsch and Negrete (1972) conducted research on communi-
cation between doctor and patient in an emergency clinic of a children's
hospital. They recorded eight hundred conferences between triads of a
child, his mother, and a doctor. Subsequent to their conference, they
questioned the mother about her satisfaction with what the doctor had
said and done. The mothers were interviewed again after fourteen days
to learn whether or not they had followed the doctors' instructions.
The authors report that 76 percent of the mothers were "highly" or
"moderately" satisfied with the doctors' general performance during
their encounter in the clinic. Specific reactions, however, were less
favorable. Nearly one fifth of the eight hundred mothers felt they had not received a clear statement of their child's condition and almost half of the entire group were still puzzled after their talk with the doctor as to what had caused their child's illness. In accord with the findings by Davis discussed earlier, Korsch and Negrete reported a substantial correlation between the mothers' expressed satisfaction with the doctor and their compliance with his advice.

Korsch and Negrete also report that their study confirms the general impression that physicians tend to use language too technical for their patients. In more than half the cases, the physicians utilized medical jargon. Although such usage did not necessarily bring the mother dissatisfaction—some were impressed and even flattered—it did leave most of the mothers uninformed about important aspects of the child's condition. It is interesting to note that satisfaction with the doctor's communication was not significantly higher among college-educated mothers than it was among those with less education.

Technical language did not appear to be the most serious barrier to satisfactory communication. The most common complaint among the dissatisfied mothers was that the physician had not shown sufficient interest in their anxious concern over their child. Sometimes mothers became so distressed over the inattention to their worry that they were unable to listen to the doctor at all. Mothers reported, for example, that the doctor had failed to give the child a prescription although the tape-recording of the interaction attests that he did in fact do so.

These problems are generally thought to be exacerbated with patients of low socioeconomic status. The patient's lack of medical
information, which complicates the task of giving an adequate account of an illness for persons at any socioeconomic level, is greater among the poor (Samora, et al., 1961). Because social meanings of being ill often conflict with medical meanings, misunderstandings may arise over the significance of certain symptoms (Mechanic, 1968:117-25). Financial ambiguities, differences in outlook, and discomfort arising from the social distance between the doctor and patient have also been cited as factors which complicate the therapeutic procedure (Burling, et al., 1956; Mechanic, 1969; Riessman, 1964; Robert Wilson, 1963). Published research also suggests that some problems derive from the very setting in which many of the poor are seen, the outpatient clinics associated with hospitals. Here the lack of time, of facilities, and of privacy are frequently interpreted by the patients as signaling impersonal, episodic, and fragmented treatment (Roth, 1969; Kosa and Robertson, 1969; Kosa, et al., 1969).

The body of research discussed above has pointed to the central-ity of the interaction between doctor and patient in the therapeutic enterprise and to difficulties that may arise during the encounter, but rarely is the communicative process itself examined. As a result, im-portant questions are left open. These will be designated in the fol-lowing section.

Questions Unresolved in Former Research

As was pointed out earlier, one of the factors contributing to the importance of the interaction between doctor and patient is its role in the discernment of symptoms and diagnoses. Ostwald's description of
the formulation of diagnosis as consisting in taking messages sent from
the patient (symptoms) and interpreting them in accordance with "certain
rules" about syndromes of disease is meant to underscore the importance
of the communicative process. But without any accompanying analysis of
that communicative process, we do not know how the doctor makes sense
of the patient's messages, how he applies those "certain rules," or how
he establishes their relevance to a particular case.

The investigations regarding patients' adherence to doctors' advice stress the importance of the interaction between the doctor and
patient but deal with attitudes towards each other expressed by the
doctor and patient and not with the process of understanding. As a
result, we are not told how those attitudes affect the interaction and
how the interaction in turn influences the patients' decision concerning
compliance. The study by Davis, cited earlier, was intended to correct
this shortcoming. Davis did record and examine the interactions, but he
coded the verbal material into the twelve categories of action developed
by Robert Bales (1951). The weakness of this method lies in the fact
that we do not know how the two people involved in the interaction, the
doctor and patient, made sense of each other's talk. No matter how
"reliable" the categorization of a given statement may be across coders,
the speakers' own intentions and reactions are not captured.

In Jacobs's investigation of mothers' encounter with doctors concern-
cerning their retarded children, we have a report on the participants'
attitude toward the interaction, i.e. that it was unsatisfactory. But
the prior issue as to what is required for satisfactory communication
to occur is not addressed. An investigation into the sense-making
involved in an interaction could answer such questions as how the doctor arrived at his (erroneous) diagnosis and on what basis he decided to withhold his conclusions from the mothers.

The conference between the doctor and patient was also left unexamined in the study by Pratt, et al. As a consequence, we do not know what the interaction consisted of, only that many did not contain lengthy discussions of the nature of the patients' illness. According to the investigators, the doctors who chose to delete such discussions did so on the basis of their judgments that the patients had a poor grasp of the medical field. What were the bases for those judgments and how did the doctors legitimate them and the course of action derived from them?

The studies isolating various attitudes characteristic of the poor which exacerbate problems in communication in a medical setting do so without a concomitant analysis of actual encounters. As a result, the nature of the connection between these attitudes and communicative troubles is still unknown. The specific ways disruption occurs need to be elucidated.

Besides the work of Davis, the studies that do examine the interaction between the doctors and patients are those by Korsch and Negrete and by Plaja, et al. Korsch and Negrete performed their analysis on the taped interchanges by coding the content in accordance with an adaptation of Robert Bales's categories; that is, each sequence of the interaction was designated as signaling negative affect, neutral affect, or positive affect. Again, their method does little to advance our understanding of the processes of communication because we do not
know how the participants themselves perceived each sequence.

A similar difficulty applies to the investigation by Plaja, et al. Besides their effort to determine numbers of patients who could define certain medical terms, they also listened to the recorded sessions and categorized the doctors and patients into characteristic modes of "presentation of self." The questions remain as to how the doctors and patients understood the interaction and whether the participants assessed the import of one another's behavior in the same way as did the analysts.

The questions left open by previous research, then, have to do with the interpretive work whereby doctors and patients make sense of one another's statements. I shall argue that the issue remains unresolved not so much because of methodological difficulties but rather because of theoretical ones. In fact, the basic assumptions of the theoretical perspective underlying previous investigations preclude the possibility that the issue will be adequately resolved. These assumptions and their consequences are stipulated in the following section.

**The Theoretical Perspective of Former Research**

A fundamental reason for deficiencies in current research lies in the theoretical perspective regarding interaction that is guiding the investigations. This perspective is grounded in conceptions of static role-sets. The assumption is that the doctor and patient are acting in accordance with behavior prescribed as typical and expected for persons in the medical setting. Consider the following statement by Plaja, et al. regarding their conceptual approach:
The relationship that develops between the doctor and his patient is governed by a vast network of rules of conduct which sets the standards of behavior. The substance and quality of this interpersonal contact is shaped by the perception that physician and patient have of each other and such perceptions are influenced in large part by the social and cultural forces that form the matrix for communication (Plaja, et al., 1968:161).

This view that the relevant features of interaction are accounted for ultimately by the enactment of culturally sanctioned expectations--roles--is echoed in the study by Korsch and Negrete. Although not so clearly stated as in the quotation above, it underlies their concern over bias:

The large size of the samples (both of patients and of physicians) tended to correct for the bias of extraneous personal factors such as social or educational background when the responses of the group as a whole were considered (emphasis added) (1972:68).

When the concept of role is taken as the primary unit in the analysis of interaction, persons are seen as filling the role and are not only considered by the theory as more or less interchangeable, but efforts are made in the design of the study to make them interchangeable by disregarding "personal factors."

Davis too subscribes to the idea that interaction is governed by role-expectations to which the participants are subject. In his words,

Presumably, all doctors and patients have certain ideas about the kind of relationship they should have, and the kind of roles they are expected to play (1968:279).

On the basis of this view, his topic for research becomes the ways in which doctors and patients "... conform to expected ways of behavior. . . ." (1968:279). In his hypothesis for his study on
compliance with the doctor's advice, he makes the conceptual priority of role very clear:

It was hypothesized that those patterns of communication deviant from prescribed institutional doctor-patient relationships will result in patients' failure to comply with doctors' advice (1968: 282).

The investigative task then becomes one of discerning how an actual interaction measures up to the "prescribed institutional" relationship. The assumption is that the requirements of the role are clear and that if the doctor and patient properly subscribe to them, communication is not problematic:

Communication between doctor and patient ideally necessitates a certain degree of reciprocity. Each person has certain rights and obligations. When the doctor performs a service, the patient is obligated to reciprocate . . . by cooperating with the doctor in their interaction. . . . (1968:284).

A pattern of communication which does not match what the investigator takes to be the normative pattern receives a "deviant" classification. For example, if a patient assumes an active, authoritarian role and the doctor assumes a passive, permissive role, their interaction is counted as a departure from the norm. Such departures are described as impediments to effective communication.

This conception of interaction also provides the guiding perspective of two frequently-used (and oft-cited) texts in the sociology of medicine. In Medical Sociology, Mechanic's discussion on the relationship between doctor and patient proceeds on the following premises:

Role is an important analytic tool, because we can frequently predict a great deal about a person's behavior just by knowing his social position. . . . In my conception, roles are functional-adaptive units. All social positions have associated with them particular tasks which require specific
patterns of behavioral enactment. . . . Thus certain task skills and associated attitudes and values become patterned. . . . Moreover, since we participate in social life in terms of our anticipations of others' social position and expectations, "role stereotypes" are required if social life is to flow smoothly. . . . Roles are the shells within which adaptive struggles take place. . . . (1968:78-79).

Interaction between the doctor and patient, including even the "adaptive struggles" that may occur in any specific relationship, is subject then to the expectations appropriate to their respective positions. Acting out these roles oneself and being able to anticipate that others will act in accordance with theirs insures that social life will "flow smoothly" and in addition produces patterned arrangements of attitudes and values.

The other major text in medical sociology is The Doctor and His Patient by Samuel W. Bloom. According to Bloom, the framework from which to interpret the relationship between doctor and patient includes three elements: culture, social role, and social system. The importance of the concept of culture for his model lies in its provision of . . . relatively standardized prescriptions as to what must be done, ought to be done, should be done, may be done, and must not be done (1963:64).

These cultural norms regulate patterns of expected behavior, the latter phrase being his definition of social role. A social system consists of two or more people interacting according to stable social roles. Bloom's model, then, instructs him to regard a specific patient and his doctor " . . . not simply as two human individuals spontaneously interacting together" (1963:73). Each is playing a social role, specifically, the role of patient and the role of doctor. They enter the relationship with expectations concerning their own and each other's appropriate
conduct. That these general expectations are represented with great variation among individual doctors and patients is regarded as "self-evident" (1963:96). Notice is also made of the fact that "... actual behavior may not conform to these role expectations..." (1963:71). Nevertheless, "... they are always there and exert a significant force upon the social system" (1963:71). In other words, the notion of role retains its primacy as an explanatory device for the analyst even in the case of disharmony. When disruption occurs in the relation between doctor and patient, the cause is laid to an incompatibility between the particular role-definitions subscribed to by a given doctor and patient or to particular dispositions that interfere with conformity to what would otherwise be compatible roles.

In summary, these theoretical approaches conceive of interaction as a normative order governed by sanctioned expectations to which the participants are subject. These sanctioned expectations are termed role-expectations and are organized into sets so as to constitute the defining attributes of a given position, termed a status (e.g., the status of doctor or patient). The role-expectations of one status are differentiated from those associated with other statuses. It follows, then, that when two individuals interact successfully, they each do so subject to the role-expectations attached to their respective statuses. An underlying assumption here is that there is cognitive consensus, i.e. that substantial agreement obtains among individuals as to the nature of a specific situation, what statuses are involved in it, and what expectations are appropriate to those statuses. Because these are believed to be perceived in virtually the same way by all parties to the
setting, the analyst studies the interaction to discern the relations between the individual's attitudes and his role-expectations, the existence of conflict between roles, the degree of conformity to the roles, and the factors that support and reinforce adequate performance of the role.

Since from the point of view of this normative paradigm, interaction can be explained by referring to the roles and their concomitant expectations that govern the participants, it frequently happens that what has actually occurred or will occur in a specific interaction is taken for granted. That is to say, because the notion of role has conceptual precedence over the interpretive work done by the participants to interaction, and because the accomplishment of understanding is treated as a given insofar as the participants adequately perform their roles, then observing the communicative process itself is regarded as needless. It is enough to identify the attitudes of the participants toward complying with their respective roles (and the factors that may affect these attitudes) and then predict what will happen or must have happened during their actual meeting. As was pointed out earlier, this course was followed by many of the investigators whose expressed intention was to elucidate patterns of communication between doctor and patient. Even when this course is eschewed and the interaction itself is examined, the assumption of cognitive consensus allows the analyst to code sequences of the conversation into pre-arranged categories and study the categories instead of the conversation. All participants (doctors, patients, and researchers) are presumed to have construed the interaction in the same way, that is, in accordance with commonly-known
and commonly-shared cultural prescriptions regarding interaction in a medical setting.

The pragmatic difficulty with the foregoing perspective is that we are left with all the unanswered questions mentioned earlier in the discussion of previous investigative efforts. The theoretical difficulty with the normative perspective has been pointed out most clearly by Cicourel:

The sociologist's model of actor competence and performance remains implicit and does not address how the actor perceives and interprets his environment, how certain rules govern exchanges, and how the actor recognizes what is taken to be "strange," "familiar," "acceptable," etc., about someone so as to link these attributes with a preconceived notion of status or role (1970b:9).

That is to say, the conception of interaction as an enterprise governed by role-expectations generally leaves out any explicit statements about the very element needed to make it work—the procedures whereby the actor makes sense of the situation and finds the relevance of any known role-expectations to his present interaction. The questions left open on both the pragmatic and theoretical levels may begin to be answered by grounding an investigation on a conception of interaction that allows us to take as a topic what was formerly treated as a given.

An Alternative View of Interaction

An alternative perspective as set forth by Wilson (1970) proposes that "... interaction is an essentially interpretive process in which meanings evolve and change over the course of interaction" (1970: 67). In this paradigm, the standing of the concept of role changes from a part an individual plays to a construct an individual uses to make
sense of what his partner in interaction is doing. In Turner's words:

The idea of role-taking shifts emphasis away from the simple process of enacting a prescribed role to devising a performance on the basis of an imputed other role. The actor is not the occupant of a status for which there is a neat set of rules—a culture or set of norms—but a person who must act in the perspective supplied in part by his relationship to others whose actions reflect roles he must identify (1962:23).

In other words, the individual perceives the behavior of another as patterned action shaped into a role and on the basis of his assessment of what that other is intending, formulates his own course of action. This assessment may change in light of future actions so that the process of interpretive work is seen in this paradigm to be continually required.

Garfinkel elaborates further this process of interpretive work in his discussion of the documentary method:

The method consists of treating an actual appearance as "the document of," as "pointing to," as "standing on behalf of" a pre-supposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of "what is known" about the underlying pattern. Each is used to elaborate the other (1967:78).

Due to this mutual elaboration, later appearances may lead to an alteration in the perceived underlying pattern, in which case the meaning of previous appearances will also be revised.

Wilson applies Garfinkel's formulation to the discussion of interaction by speaking of role-taking as a process in which an individual sees the actions of another as standing on behalf of an underlying pattern or role. The underlying pattern consists of the context of the interaction, the motives, sentiments, and purposes. Each action during the course of the interaction is understood by the individual from the standpoint of its place within this context. That is, a given action is
interpreted on the basis of what has preceded it and what may be presumed to follow it. Furthermore, there is a mutual elaboration between the underlying pattern or role and the individual actions so that the context itself is seen for what it is through the very action it is used to interpret. Any change in the assessment of one will alter the sense of the other. Again, then, interaction is viewed as a process of continual interpretation where revision is always possible.

If interaction is to be viewed as an interpretive process, what is required is a theoretical perspective that will allow us to take that interpretive process as the topic of study. Although the perspective provided by symbolic interactionism conceives of interaction as an interpretive process, some aspects of the theory resemble the normative paradigm and therefore share in its difficulties. Consider, for example, the exposition of symbolic interactionist theory provided by Arnold Rose (1962). Having defined symbols as "common or shared meanings and values" (1962:6), he makes the following statement about interaction:

Communication by means of significant symbols . . . involves words or gestures intended to convey meaning from the communicator to the observer. It is not the noise of the words or the physical movement of the gesture itself which communicates, but the meaning for which the noise or physical movement stands as a symbol. Both the communicator and the observer have had to learn the meaning of the words or gestures in order to communicate symbolically. . . . (1962:8).

In other words, actors share a common language—a system of shared significant symbols—and through this sharing, they overcome their individual standpoints and are enabled to interact concertedly with one another.

Although this view moves toward locating the possibility of orderly interaction in the individual rather than institutionalized rules
and values of the society invoked by the normative theorists, Arnold's discussion of role essentially parallels the normative perspective:

The symbols—and the meanings and values to which they refer—do not occur only in isolated bits, but often in clusters, sometimes large and complex. The evocation of a lead meaning or value of a cluster will allow fairly accurate prediction of the rest of the meanings and values that can be expected to follow in the same cluster. . . . The term role will be used to refer to a cluster of related meanings and values that guide and direct one individual's behavior in a given social setting. . . . (1962:10).

The parallels are seen in his reference to the predictive value of the concept of role and to its directive power. Zimmerman and Weider (1970) elaborate the nature of the similarities in the two approaches:

. . . whether couched in the language of norms, as in the case of [the normative paradigm], or shared emergent meanings, as in the case of interactionists, the end result is the same: stable social action is the product of the actor's orientation to and compliance with shared, stable (if only within a particular interaction) norms or meanings. Norms, or meanings, presumably govern, guide, direct, and for the analyst, account for action. To assume that these subjective but intersubjectively shared constructions perform such functions is to make them available as a resource for social-scientific analysis and explanation of regularities in social life. That is, the description of such shared norms or meanings presumably provides the analyst with the resources for predicting and explaining actual events in the society (1970:288).

The difficulty here is that the linguistic rules which govern the use of language are open-ended just as are the role-expectations of the normative theories. That is, neither linguistic rules nor social norms contain within them all the contingencies to which they apply. The actor must decide the appropriate time to use a term and must decide its specific meaning on the occasion of that use. The nature of this interpretive work is omitted from the symbolic interactionist approach as well as from the normative approach.
To take the interpretive process involved in interaction as a topic, we can follow the proposal of the ethnomethodologists and suspend the assumption that interaction is governed either by social norms or by shared symbols except insofar as the participants themselves may invoke such notions in describing and explaining the sensible character of their talk (Zimmerman and Weider, 1970:288-89). Thus, primary attention turns to this practice and any others whereby members "assign" sense to one another's talk and actions.

Because its concern is with the nature of the interpretive process, the ethnomethodological perspective has been followed in this present investigation. The basic elements of this perspective have been detailed elsewhere and need not be repeated at length here (Garfinkel, 1967; Douglas, 1970; Cicourel, 1964, 1970a; Zimmerman and Pollner, 1970; Leiter, 1971, 1974). But one further point does need to be mentioned. A central tenet of ethnomethodology is that it is through their accounts —their talk—that members make available to themselves and to others the orderly, sensible character of their undertakings. The focus of study, then, is on determining the features of these accounts. Therefore, ethnomethodological investigations seek to describe members' accounts

... wherever and by whomever they are done, while abstaining from all judgments of their adequacy, value, importance, necessity, practicality, success, or consequentiality. We refer to this procedural policy as "ethnomethodological indifference" (Garfinkel and Sacks, 1970:345).

Subsequent chapters will be dealing with the accounts by doctors and patients of the sense-making during their conversation, of their attitudes, judgmental work, assessments, and so on. In accordance with
the above procedural policy, we do not raise the question as to the "authenticity" of their remarks, that is, whether they "really" thought what they say they thought. Instead, their statements will be taken as their attempts to provide a rational accounting to me of what happened between them and an attempt will be made to search out the properties of such an effort. As Garfinkel proposes:

... the activities whereby members produce and manage settings of organized everyday affairs are identical with members' procedures for making those settings "account-able" (1967:1).
CHAPTER TWO

METHODS

For an investigator to claim scientific status for his endeavors, he must ground his theoretical notions in empirical observations and must establish his findings as valid by making them publicly shareable, i.e., objective. This objectivity is not accomplished by purging the findings of all the effects of the mind that found them, for such an attempt is futile. As Polanyi has argued, "... the ideal of eliminating all personal elements of knowledge would, in effect, aim at the destruction of all knowledge" (Polanyi, 1967:20). Even to move from a quest for strict detachment to a call for freeing the findings from the situation in which they were discerned sets up an unreachable goal. Any act of knowing

... relies on interiorizing particulars to which we are attending and which, therefore, we may not be able to specify, and relies further on our attending from these unspecifiable particulars to a comprehensive entity connecting them in a way we cannot define (emphasis added) (Polanyi, 1967:24).

The "freeing," then, will be only partial, the success merely relative. The aim becomes one of requiring the investigator so to examine the situation in which he locates his findings that the terms of his knowing are specified, albeit incompletely. In this way, his findings are made communicable, for they are provided with a context that allows them to be seen in the same light he saw them. And further, in this way he makes it possible for his endeavor to be (partially) replicated, for he
has given information necessary for a colleague to construct the same kind of situation. It is in view of these considerations that the following details pertaining to the present study will be given.

First, the original design of the project will be described. Its evolution into the actual accomplished design will occupy the remainder of the chapter. No plan travels the route from the ideal to the real unscathed.

At the outset, my plan was as follows: In the six public health clinics of Harris County, Texas, I would conduct research on the processes of communication between doctor and patient. Methods chosen for the study included observation, analysis of tape-recorded interaction, and interviewing. Observation would center first on the physical arrangement and organizational procedures of the clinics. Once familiar with the setting, I would approach a patient who was in the waiting room and about to see the doctor, and request his participation. When agreement was obtained, I would observe and record the conversation between him and his doctor, taking care to note gestures, facial expressions, posture, and any other situational cues to what occurred between them. Following their session, I would conduct separate interviews with each participant according to a set of questions I had composed prior to their conversation, supplemented with questions specifically concerning their talk together. These interviews, along with their original conversations, would be transcribed literally and annotated with descriptions of the non-verbal cues I had noted. To analyze the data, I would set the original conversation up against the step-by-step commentary on it supplied by the two participants and thus be able to ferret out the
processes they had used to communicate with one another and to accomplish the purposes of their meeting.

Alterations in this idealized plan began during the preliminary phases of securing the permissions to conduct the study. Initial authorization had to be sought from Dr. Carlos Vallbona, chief of community medicine at Baylor College of Medicine and administrator of the clinics. After several meetings together, I submitted a written proposal which he, in turn, submitted to the officials of the Harris County Hospital District and to Baylor's Committee for Research Involving Human Beings. When these bodies notified Dr. Vallbona that their permission was given, he wrote letters to the administrative head and chief doctor at each clinic describing the project and giving his approval contingent upon their consent. Therefore, this initial and primary approval was periodically re-negotiated during the period of the discussions with the personnel at each clinic.

My troubles in obtaining these individual consents were legion. In the first place, five of the clinics are located in sections of Harris County unfamiliar to me, and I repeatedly and regularly lost my way. Second, appointments with the personnel of the clinics often did not come to pass. I would arrive (finally) only to find the clinic had been closed due to a power shortage, the doctor had been detained at a meeting, the administrative head had had to assume nursing duties for the day, the letter from Dr. Vallbona had not arrived or had been misplaced, and so on, with the list of unscheduled occurrences that arise nevertheless routinely.

Third, when circumstances eventually permitted an appointment to
be kept, I found that the people who staffed the clinics had definite ideas as to what constituted a proper design for a sociological study and as to what purposes they hoped to accomplish through the project. That is, they evinced a concern that the study be designed in such a way that the sample of patients be large and that it be representative with respect to types of personalities offered by the patients, or to randomness of selection, or to the course of interaction when no observer is present. As for the purpose of the study, they often wanted me to gather information that would permit me to give them advice about how to "make things better" at the clinics.

These ideas on the part of the staff and the ways I dealt with them will be discussed below. But first I would like to point out that the reason these questions were raised at all is that research conducted on the basis of surveys has fostered many misconceptions about the investigative process. As a result, it is very difficult for any other type of research to be considered acceptable and legitimate. Thus, the essence and amount of truth received is considered to rest on the numbers of people who are studied. If it is not feasible to study all the people relevant to the issue being investigated, then a method of selection must be followed that will result in a group who can stand as typical of all those others along certain designated dimensions. Survey research in which questionnaires are passed out to a random or structured sample is regarded as the way to conduct an investigation because it reaches the most people and furthermore results in data that is most easily coded and analyzed.

I would like to address these notions from three directions.
The first has to do with the locus of truth. The second involves the matter of sampling. The third questions the assumption that any particular method of research holds exclusive claim to legitimacy.

The first and second matters are addressed in the following excerpt from the *Proceedings of the Purdue Symposium on Ethnomethodology* (Hill, 1968):

**Gold:** I get a feeling from your own discussion that you have the same kind of sampling approach that one takes in agriculture. When you want to sample a seed in the bag, you take a tube and you put it right down through the bag because you know that it is homogeneous. You seem to be talking about human behavior as homogeneous.

**Sacks:** No. Anything he draws up in the tube is human behavior.

**Sudnow:** That's right.

**Hill:** Do you want to be able to have grounds for talking about the relationship of what is pulled up in the tube to what isn't?

**Sudnow:** I will try to build descriptions which will reproduce a piece of behavior, it may very well turn out to produce a lot of other particular pieces of behavior also.

**Gold:** That's an open question.

**Sudnow:** That is an open question. In any case, I will be happy if right now I can find an account which would produce a particular behavior. That would be for me an accomplishment which social scientists have not been able to make. Social scientists have not been able to reproduce any particular instance. They can reproduce general instances all day long, they have not been able to build a set of categories or an analysis which would provide for a particular thing as a product of that particular analysis (1968:67-68).

In other words, whatever truth results from an investigation does not rest on the numbers of people investigated but rather in the sense the researcher makes out of the investigated behavior, however few or many
instances of it are involved. Moreover, the generality of that constructed sense must be settled after the fact. Designating a sample as typical of a given population assumes a good deal of knowledge about the factors relevant to the topic under study, and for many topics concerning social behavior, this assumption is premature.

As for the third point, no tool for gathering data holds exclusive claim to legitimacy. It will be shown later in this chapter that relying on the use of a questionnaire in this study would have resulted in erroneous conclusions regarding certain aspects of the proceedings at the clinics. But even more basic is the point that the primary topic here regards the very interpretive work that would produce the responses to a questionnaire. For example, a "yes" response to an item asking, "Did you understand what the doctor/patient said?" is meant to tell the analyst that understanding occurred, but not how. When a survey questionnaire cannot tap the information the analyst seeks, then obviously it should not be used. The legitimacy of a tool depends entirely on its capacity to serve the purposes of a given investigative effort.

I did not offer the above apologia in dealing with the questions raised by the clinics' personnel about the design of the study. My chief pragmatic motive was to gain entry, and challenging sacred cows is not a very endearing procedure. The strategies I followed to handle the concerns growing out of years of experience with the survey are detailed below.

With respect to the design of the study, concern centered on the size and representativeness of the sample of patients. These two matters will be discussed in turn. The size, it was argued, should be
large. At the same time, the amount of time seen as available for each doctor to devote to the project approached zero. Two patients per doctor had been settled on as not too intrusive, but the number sounded uncomfortably low to the personnel. And so, when questions arose regarding numbers, though I thought the argument essentially irrelevant in light of the nature of the study, I spoke of the fact that there would be two patients per doctor, several doctors per clinic, six clinics in all. This way of counting made the total sample sound respectably large and the subject was regarded as agreeably settled.

In the end, the size of the group of patients and doctors studied was thirty-three, eleven doctors and twenty-two patients. My idealized plan, still intact when I began gathering permissions and therefore presented as the plan, did indeed project that all the doctors at all the clinics would be involved. What happened in the course of events was that one of the clinics did not participate. (The circumstances surrounding this case will be discussed later in the chapter.) Furthermore, "all the doctors" at the remaining five clinics turned out to be a very large and everchanging group. There were medical students in various stages of a brief training period. There were doctors temporarily substituting for colleagues on leave or on vacation. There were numerous doctors in private practice who served the clinics for only a few hours a week. And there were doctors whose status was in the process of changing from one category to another. To set some limits on this flux, I decided to seek out as participants all the doctors who served the clinics "half-time" or more, and whose involvement the staff counted as "permanent." This way of choosing meant that thirteen
doctors were eligible. Two declined, one on the grounds that he spoke in Spanish to his patients, the other never agreed to see me at all.

The other matter regarding the design of the project that was of some concern to the personnel of the clinics was the representativeness of the group studied. This concern took three forms. First, some of the personnel were concerned that I observe a "cross-section of personality types." Initially I tried explaining that any conversation would be acceptable data and that whatever the doctor had to deal with on the days I worked with him would be adequate for the purposes of discerning processes of communication. When that approach failed and the doctor or administrator continued to recommend the value of "using some extrovert types and some quiet types," I pursued the following course. I suggested that, since they knew the patients so well, if they would pick out for me what they would regard as representative patients, I would be very grateful to them and use their selections as my subjects. This solution was deemed meritorious.

Several weeks later, however, when all the permissions had been obtained and the time actually came to request permission from a patient just prior to his seeing his doctor, I made the approach. When I notified those members of the staff who had suggested they do the selecting that it was now necessary to indicate their choices, they said they were busy (or tired) and for me to choose whomever I wished. They offered to help me if I met with any difficulties. So I determined which patient was next in line to see the doctor and asked for his cooperation. (This course was the usual one. On three occasions, the doctors invited me into their office where a session had already begun. My talk with
those patients occurred at the time of my entrance.) I showed the patient the consent form written in accordance with requirements of the granting agency for the project and the governing bodies of the clinics. (A copy of the form is included in Appendix A.) We read it together and I elaborated on the explanation contained therein regarding the nature and purposes of the study, taking special care to stress that participation was entirely a matter of his personal choice, that his privacy would be protected, and that he could withdraw his agreement at any point. Sometimes it was necessary to repeat the explanation again and again until I was satisfied that the patient understood what was required of him. On only two occasions was the patient's decision a negative one.

The second form in which a concern with representativeness appeared surrounded the issue of randomness. Some of the members of the staff did not think the plan outlined above would result in selection at random. My explanation that a conversation between any doctor and any patient would be acceptable data—i.e., essentially side-stepping the issue—fared no better here than it did with those who wanted a non-random sample picked on the basis of "personality types." Finally I argued that in any study, whether based on questionnaires, experiments, survey, or interview, the investigator has as subjects only those who at some stage agree to participate. This assertion had somewhat better success. The three who still held to their position following my first two efforts in the end gave in on practical grounds. That is, I asked for them to suggest a way to achieve their idea (whatever it was) of a random selection. No suggestions were forthcoming and we
agreed to proceed on the basis of my flawed but practicable plan.

The third form in which a concern with representativeness appeared was in the statements of two doctors who thought my presence during the interaction between them and their patients would significantly alter the character of the proceedings. Dr. Warren suggested that in order to see what was "really going on" I should secretly plant a recording device in his desk drawer. We agreed that the illegalities of this procedure posed an insurmountable obstacle and again on the grounds of practicality, my plan was accepted.

Dr. Ferguson pointed out quite specifically how he thought my presence would affect his session with a patient. He proposed that were a doctor in a bad mood, his communication with a patient would be poor. But with me there, he would hold onto his temper and do his best in order to make a good impression. Was I willing, he asked, to do a study that included no representative of those sessions where the doctor lost his disposition? I replied that since those situations were unavailable to me in any case, according to his specification, I was willing to proceed on the basis of whatever was available. And further, I explained that I believed him perfectly correct that observation alters the thing observed and that part of the task is to take account somehow of the features of that alteration. In the case of my study, I told him, I intended to ask the participants to specify in what ways my presence had affected them. He said he was not concerned with what effect they said it had, but with what effect it really had. As I debated with myself the wisdom of explaining the notions regarding accounts and their truth-value discussed in Chapter One, he dropped the discussion and invited me
to go find two patients to observe with him.

I mentioned earlier that, besides encountering some definite ideas about how the study should be designed, I also had to deal with some definite ideas about the purposes of the study. My usual response to questions about purpose was to stress first what it was not. That is, I was not there to score the doctors on some scale of good and bad. My assumptions were that the work was being accomplished at the clinics—they were, after all, in business and ongoing—and I wanted to discover the manner in which it was accomplished. Principles discerned from the study regarding the nature of interaction and the processes of arriving at a diagnosis could be used in teaching medical students. The members of the staff generally accepted these remarks, adding that "we know we have our problems" and expressed interest in my report of any I discovered. My remarks, however, were not acceptable at one of the clinics—Scarsdale Clinic.  

When I met with the administrative head at Scarsdale and described the project, she agreed with the plans until she learned that I do not speak Spanish. Though I had known that most of the patients at the clinic speak Spanish, I also knew that the clinic had some patients (about fifteen percent) who speak English and had intended to observed only those. The administrative head said that their English-speaking patients were "so unrepresentative" of their larger population of patients as to render my study useless to the clinic. In time, the doctors joined our meeting. They also wanted me to observe the Spanish-speaking patients because they wanted me to check out for them the quality of those interactions. They were concerned about their own
fluency. However, since I was not equipped to do so, they eventually indicated a willingness to participate in the project (over the continuing objections of the administrative head), pending approval from the neighborhood council. In an attempt to bolster the reluctant support, one of my advisors spoke with the doctors. The outcome of the council meeting, however, made his efforts superfluous.

At the meeting of the council, there were five residents of the neighborhood and a minister who acted as leader. He introduced me and as I explained the project, he translated for the other members. Everyone nodded and smiled throughout the proceedings and I thought all was well. Then another minister came into the room. After being told about the project, he began a lengthy statement about how these people had been "studied to death" with no tangible effects, how research money is wasted on professional investigators and should instead be given to the people—they already know what the needs are—and in general how wrong-headed the whole system is in America. He spoke sometimes in English, sometimes in Spanish, enough in Spanish to wipe away those expressions of smiling approval I had seen earlier. Rarely was I able to make a response and the few I made were not translated. Finally I asked if there were any conditions under which he would consent to the study. His condition was that I guarantee him some definite ways in which the clinic and its people would benefit from it. I thanked him and the council and said I would call later. When I was able to meet with Dr. Vallbona, I informed him of these events and expressed considerable reluctance at making any promises to improve anyone's situation. We agreed that it was best to exclude Scarsdale from the study.
By outlining the troubles in securing permissions even at the clinics that did become a part of the study, I have not meant to imply a lack of cooperation on the part of the personnel. Once the study was begun, all members of the staff at each clinic helped me unstintingly. But to gloss over the early proceedings by simply writing "permissions were secured" leaves out of account an important step in the shaping and accomplishing of the project.

Once this process of gaining entry was completed, I spent a period of weeks observing the daily functioning of each clinic, talking with members of the staff, and becoming better acquainted with those whom I would later interview more formally. In the next chapter, matters regarding the routine operations of the clinics and the doctors' and patients' observations about the clinics will be addressed. The present chapter will proceed to a discussion of the interviews.

An interview is essentially a social interaction and is subject to all the vagaries thereof (Goode and Hatt, 1952). Just as in any other conversation, each party to the interview is faced with managing the presentation of himself and his ideas to the other. In his *Method and Measurement in Sociology*, Cicourel has specified the unavoidable problems basic to the interview as well as to the ordinary exchanges of daily life (Cicourel, 1964:99-100). I shall paraphrase his summaries and use them as a way of setting forth the nature of my interview with the doctors and patients.

1. The character of the responses depended on trust, differences in status, diverse interpretations of the questions and answers, attitudes toward the enterprise, and so forth. These factors operated
in undetermined ways and, moreover, varied not only between interviews but also over the course of a single interview. Trust grew or, in places, wavered. Behavior formulated or understood at the outset on the basis of general typifications regarding status, i.e. regarding age, education, sex, socioeconomic class, and race, were frequently altered as the relationship became more personal. As for difficulties over interpretations of questions and answers, consider the following excerpt from an interview undertaken late in the study. Here difficulty arose over questions that had caused no apparent problems in other interviews.

I: Tell me a little about what you think of the clinic from the times you've been here.

Pt: Whatcha mean by that, I mean, if you think uh, mmm. (Pause)

I: Well, what's your impression of the clinic? (No answer. No light of recognition in her eyes.) Like, would you tell your friends it was a good place to go if they were sick?

Pt: Ycuh, mm hmmm. (Long pause while I waited for some more. None came.)

I: What procedure do you have to go through? What are the steps you have to go through when you get here before you get to see the doctor? (Long pause. So I start again.) When you first. . . . (Then she finally says something.)

Pt: (First couple of words are unintelligible.) . . . interviewed and . . .

I: What?

Pt: Interviewed and then see the doctor, is that what you mean?

I: Yeah.

Pt: Mmm hmmm. (Pause)
I: Well, uh, like today, when you came in . . . (I paused, but there was no sign of responding) you just went in and turned in your appointment slip?

Pt: Mm hmm. (Then nothing more, though I waited.)

I: And then? (I waited.)

Pt: Then they called my name to take my blood test and then I came on in (unintelligible—she trails off inaudibly).

As I mentioned, this interview occurred late in the study, and the questions about the clinic’s procedures had posed no apparent difficulties for the other patients. Which is to say, problems concerning interpretation cannot always be foreseen and therefore cannot be prepared for in advance. Each time is a first time.

As for attitudes toward the enterprise, the participants' statements of their feelings about my presence during the original interaction and about answering my questions will be presented later in this chapter. My own attitudes were based primarily on a concern not to exploit unduly the patient's willingness to cooperate and not to invade unduly his privacy. What constituted "unduly" had to be determined on the spot, depending on the hour, the ailment, the uneasiness evident, and so on. My attitudes toward the doctors were based primarily on a concern not to alienate them by seeming to challenge the accuracy of their decisions. Sometimes, my efforts to avoid this impression failed and had to be redoubled.

I: When the patient said back there at the beginning that she had passed out, what did you take that to mean?

Dr: Uh, I didn't think it meant anything physically that much but just part of her anxiety-depression she's going through, you know. So I didn't, you probably wondered why I didn't question more about it and all that, order lab work and all like this, I'm just . . .
I:  No, I didn't. No, I just wondered if you took that to mean she actually lost consciousness or . . .

Dr:  (interrupting) No, I didn't think she did.

The point of all this discussion is that no matter how prepared and careful and aware I tried to be, contingencies arose that had to be dealt with in the midst of the interaction. That is, trust had to be bolstered, stances towards one another had to be shifted as familiarity increased, difficulties in answering questions had to be resolved, attitudes of uneasiness had to be assessed. Preservation of the integrity of the situation was a continuous enterprise.

2. The desire to pursue a response in search of depth, consistency, or clarity always had to be balanced against the danger of creating feelings of uneasiness and patterns of avoidance on the part of the respondent. Uppermost in my mind was the specter of Garfinkel's experiments wherein he showed that pushing too far with "What do you mean?" leads to total disruption of conversation and brings interaction to a standstill (Garfinkel, 1967:35-44). The more "commonplace" the remark I was pursuing, the more clearly I saw the specter. Questions such as "What do you mean when you say you think the doctor is nice?" or "What were you judging by when you said the patient didn't look like she was in much pain?" were asked with fear and trembling. Sometimes I backed off early. For example, one of the doctors told me he had asked his patient if he had any mouth sores in order to check out the possibility of a vitamin deficiency. When I asked the patient what he thought was behind the doctor's question, and he replied, "I guess to see if I had a sore mouth," I decided it best not to pursue it further.
At other times, entanglement was not foreseen and once confusion occurred, I had to resolve it by answering my own question. The following excerpt illustrates such a case:

I: What did you think the patient meant when she said she was nervous?

Dr: Course I knew what she meant when she said she was nervous 'cause I knew she was depressed from had seen her before, you know. (He continues here by listing several possible things patients can mean when they say they are nervous.)

I: What did you know, from talking to her before, that she meant about being nervous?

Dr: Uh, repeat that question.

I: Well, you said you already knew what she meant by being nervous. And you went through some of the things that patients usually mean.

Dr: Mmmmm.

I: I just wondered which of those things were what you knew she meant about being nervous (Dr: Mm hmm) from other times you had talked to her.

Dr: I don't get the question.

I: Well, you were saying that being nervous could mean several different things, like (Dr: Yeah) shaking or something.

Dr: Mmm humm.

I: And I wondered what were the things that you knew she meant when she said she was nervous. (Pause. He looked totally blank.) Uh, was it just crying and not sleeping?

Dr: Yeah, crying and not sleeping and uh real uh real tense and emotional.

Decisions about when to pursue, when not to pursue, and when to quit pursuing were based entirely on situation-specific cues such as what had gone before, facial expressions, and how central I judged the issue to
be in light of what else I had to ask.

3. Both the respondent and I held meanings in reserve. Sometimes, questions I wanted to raise concerning material not volunteered had to be excluded for fear of embarrassing both of us. Though the list of possible topics for my interviews was drawn from the conversations between the doctors and the patients—conversations held in my presence—the patients were not interacting directly with me at that time. I assumed that certain questions they considered proper for a doctor to ask would be seen as improper for a sociologist to ask. But exactly which topics would fall in the latter category could not be determined in advance. For example, as I listened to the patients talk to their doctors about such matters as hemorrhoids, genital infections, urinary troubles, and sexual difficulties, I imagined these would be avoided in their talks with me. Certainly I intended to avoid them. But during the interviews, sometimes the patients themselves raised these topics with me in discussing their general health. And at times, I decided during an interview to raise them myself when a patient seemed to be especially open, frank, talkative, and appreciative of the chance to tell more about himself. Then again, questions I thought posed no risk of embarrassment ended up doing so. For one example, I asked a patient about the pain in her abdomen. After some flushing and stuttering, she hinted that it was related to "times with her husband." I pushed no further with her. The point here is that being sensitive to the possibility or presence of embarrassment resulted in much being left unstated.

4. The three preceding features of the interviews meant that
meanings remained problematic even when the intention on both sides was to clarify meanings. My own goals as investigator perforce remained subservient to the demands of polite discourse and of general regard for the patients and doctors. That is, at times the interviews had to be more brief than I had planned due to pressing circumstances. Doctors had other patients waiting, or their lunch-break pending or a colleague needing to seek his advice. Patients had already spent quite a bit of time at the clinic. Some needed to return to their jobs. Some were detaining a neighbor who had brought them. Some were experiencing physical discomfort. And some were experiencing the emotional discomfort of awaiting the results of a pregnancy test or a lung x-ray. These considerations necessarily ordered priorities regarding which questions remained a part of the interview schedule and which were excluded.

5. The basis for achieving meanings relied on the devices of common sense. Since those very devices were the ones I proposed to study, and since it is impossible to use them and study them at the same time, I could not formulate or test any theories in medias res. With attention focused on eliciting information, maintaining the interaction, and making quick judgments, I could not at the same time be aware of how or why responses were what they were. These matters had to be settled after the fact. The theoretical basis for this difficulty is pointed out by Wilson:

... in order to understand and follow the course of interaction, the researcher must engage in documentary interpretation, and in particular he must do so in order to identify what action is performed at any given moment. ... there is no way of seeing an event as an action and of describing its features other than through the documentary method of interpretation. Because actions are constituted and have their existence only through
the participants' use of the documentary method of interpretation, the researcher has access to these same actions as intended objects of description only through documentary interpretation (1970:69-70).

Added to these five features that trouble any interaction were sundry others that troubled mine. I intended for the interview to be unbroken and one-to-one. But two patients had children with them who continually interrupted us. Another's wife continually interrupted us. Interviews were interrupted by talkative security guards, by phone calls, by requests for consultations, by appeals to move from one place to another.

I intended to ask the schedule of questions in an orderly fashion. One section of the schedule, of course, was planned to be variable from case to case since it would concern the specifics of the interaction that occurred between the doctor and patient. But for ease of analysis, I had projected that the questions in this section would follow the same order as had the topics raised in the original conversation. Further, I had projected that the questions prepared in advance would follow the same order from case to case. But respondents frequently answered a question I had not asked yet. Or they added onto a previous answer during a later one.

This description of the actual procedures of interviewing in the field undermines any notions of strict standardization and invariant validity. That is, strict standardization means exposing each person in the sample to the same conditions. But the preceding discussion has shown the necessary and unavoidable variations between the cases touching every aspect from how private the interview was to how long it lasted. The ideal of invariant validity meets a similar fate. The
preceding discussion has shown that the "quality" of the responses can be expected to vary between and within interviews depending on the level of trust, embarrassment, emotional upset, physical pain, difficulty with interpreting the questions, and so on.

Still further, the foregoing description of interviewing puts to flight any fancy that a schedule of questions is "administered." It is negotiated, not administered. It is arranged and established in the midst of the practical exigencies that accompany any other interpersonal exchange.

I had intended to supplement the tape-recorded conversation between the doctors and patients by notes on non-verbal cues that passed between them. I found, however, that taking notes on the verbal exchange to serve as the basis for the subsequent interview precluded my watching them sufficiently to record non-verbal cues. Moreover, early in the study I discovered that on the occasions when I had a chance to look up from my notes to observe them, they began to include me in their conversation. They directed remarks to me, asked my opinion, made explanations to me, and so on; therefore, in later interviews, I sacrificed even the few non-verbal cues I might have recorded in the interest of preserving the examination as a one-to-one interaction between doctor and patient.

An important factor in any study is the attitude of the participants regarding the enterprise. I wish to report here the patients' and doctors' accounts of the effect my presence had on their interaction and of their feelings about answering my questions. The way they chose to present themselves to me constituted part of the context in which my own
decisions were formulated, both at the time and during the analysis.

Five of the doctors reported to me that my presence had not disturbed them. Dr. Compton\(^3\) said he "didn't mind." Dr. Hart said, "It didn't make me a bit of difference." Dr. Scott said, "It didn't matter at all." Dr. Hunter said, "Glad to have you. It didn't bother me." Dr. Henry said, "Happy to have you." He added with regard to one of the two patients:

Dr: Mr. Gulfton makes a very interesting patient and I was glad to have you here to uh see my method of approach in the matter and uh I felt that uh, that we had really, since he's been coming here, have uh created miracles with this man from the way he looked when he first came, and how he was, how he was uh suffering, so far as this dermatitis was concerned. So I was just glad to see you see what, what was uh being done for him.

Regarding his other patient, he said:

Dr: I have nothing to hide and uh I feel that I was uh treating the pa..., the patient adequately, leaving nothing here undone. We had a great big obese woman here that all the doctors in Philadelphia couldn't cure, you see? Nothing here is being overlooked, see? I thought that, I thought that, I feel still that if there's any doctor in all the world that could do any more for her I'd like to see them do it. And so, so far as I'm concerned, I uh was happy to have you.

The other six doctors described my presence as having had some effect on the proceedings. Dr. Ferguson reported feeling "a little bit artificial." He explained:

Dr: I found myself, you know, whenever somebody's sitting there talking, you, you find yourself wanting to be more communicable with the patient because that's the thing they're checking (he laughs on that word) you on. So now I find myself was saying: now wait a minute, how would I really be doing if I were, if I were checking this patient and I may have flipped back the other way, you know. It just, I was just aware of this going on, that was all.
He added that during the second observation, he felt "less artificial."

Dr. Warren said that, although he thought my presence had had no effect on his own behavior or on that of one of his patients, his other patient had been much more talkative and cheerful than usual in order to "show off" for me. He added that he wished I could be present more often. It was easier to talk to Mr. Jones in that "expansive" state.

Dr. Roberts explained the effect of my presence during the first observation in the following manner:

Dr: I think it's helpful, you know, with your sitting there because it made me slow down a little bit and think out a little more carefully the questions I was going to ask, you know, because I knew they were going to be put on tape. And I wanted to think: now is this going to sound logical to someone else who's listening to it. Is this going to sound like, you know, I'm sitting here racing through, because I don't like to, you know, race through with a patient.

After the second observation, he said he had felt "more at ease maybe."

Dr. Glass said with his first patient,

Dr: I tried to act just like you weren't there. Only thing I did different, I might have projected my voice a little bit because I had a feeling (unintelligible) microphone was picking up.

With regard to the session with his second patient, he said he "might have expounded a little bit more" and tried to "bring out the things I usually think of with patients a little bit more." He also commented that as he asked his questions to his second patient, he thought, "Now she's gonna ask me why I'm asking this."

Dr. Branch said that during the second observation, he felt "very natural" and thought his patient had also. About the first observation he said that the procedure may have been somewhat boring to the patient
because he had already gone over some topics with her before he invited me into the office. He then repeated these questions for my benefit. He also remarked that he "probably wouldn't have spent that much time with her" had it not been for me.

As for the patients' statements about the effect of my presence on them, only one of the twenty-two said it had had some effect. Ms. Franklin stated that my presence had made her "a little nervous." She said, however, that she "went ahead and asked him everything I wanted to. I just was a little self-conscious, that's all." The other twenty-one patients depicted my presence as without effect. Six said "it didn't bother me" with no further elaboration. These were Ms. Flood, Mr. Gulfton, Ms. Granado, Ms. Perkins, Ms. Rankin, and Mr. Jones. Six of the patients emphasized their assertion by pointing to a personal feature such as "I'm not a secretive person" or "I used to be shamed but not anymore." This course was adopted by Ms. Flowers, Mr. Vance, Mr. Rodríguez, Mr. Moon, Ms. Kinkaid, and Ms. Smith.

Five patients underscored their declaration that my presence had not disturbed them by making me part of the medical setting. This depiction was accomplished with such phrases as "It was just like a nurse" or "It was like in a hospital with lots of people coming in." Ms. Vaughn, Ms. Brown, Ms. Travis, Ms. McMillan, and Ms. White made comments of this kind.

The remaining four patients warranted their not feeling bothered by citing some good purpose for the project. For example, "Anything to help the clinic" or "It might help folks see what kind of operation we have here" were added onto "I felt fine about it." Ms. Hamilton,
Mr. Shore, Mr. Martinez, and Ms. Pilot made such remarks.

When I asked the doctors how they felt about answering my questions, eight replied, "It didn't bother me." Four of these added a phrase like "Glad to have you" or "Hope you get something out of it." The other three said they found the project beneficial or potentially so. Dr. Glass described the procedure as having been a process of "self-education" for him by causing him to "think about why I ask what I ask."

Dr. Roberts also stated that the process of answering the questions had been helpful to him. It had allowed him to "re-think" certain aspects of his patients' illness. Ordinarily, he explained, he has "no time" for review.

Dr. Hunter looked for future benefits. When I asked for his feelings about the interview, he responded:

Dr: It doesn't bother me, because somewhere down the line I'm thinking, if what we're doing is correct then it's nice. If it's not, then you all will tell us how to do it, you know. That, that's the way I look at all of this, you know. There has to be, it has to be done right. And so I'm always glad for this because if this can detect something, then if you straighten it out, I'll know how to go from then on.

I: I think it's more a matter that you can straighten us out.

Dr: Well, I'm just saying, either way, we want to do it correctly and that's the best way to do it is people every once in a while is somebody see how you're doing it.

The patients all reported that they had not minded reviewing their conversation with me. However, Ms. Franklin's comments included an admission of some "funny feelings.

I: How did you feel about going over these questions about your conversation with the doctor?
Pt: Well, it was alright. I didn't mind it. But it feels kinda funny being asked what did you mean when you said something. I really never thought about it. It makes you feel like you're being cross-examined, like "are you sure you meant to say that."

Eight of the patients said "It didn't bother me" with no further elaboration. Seven elaborated with a personal feature such as "I'm just me. I'll tell you the truth" or "I like to talk." Mr. Vance, Ms. Vaughn, Ms. Flowers, Ms. Hamilton, Ms. Rankin, Ms. Smith, and Ms. McMillan followed this course.

Six patients elaborated by citing their purposes for participating. These were in the vein of "If I can help [you, the doctors, somebody else, the clinic], I'm glad." Such additions were made by Ms. Flood, Ms. Granado, Mr. Rodriguez, Mr. Martinez, Ms. Brown, and Ms. Travis.

Whether these expressed feelings matched what was in their heart of hearts, I have no way of knowing. Even if they were "putting me on," it is interesting to note how they did so. That is, if they are fabricating a story for me, what procedures are they following to accomplish the normalization? As was pointed out in the preceding discussion, in order to convince me that I was not a bother, some invoked the notion of good purpose, some cited a personal attribute, and some cast me into a medical or helping metaphor. Whatever their "true" motives and opinions were, they all did in fact talk to me until the end. At any rate, my analysis was concerned with just that—how, through their talk, the doctors and patients presented their joint undertaking as a sensible and rational affair. Moreover, as instructed by the policy of "ethnomethodological indifference" discussed in the first chapter, in my role as
analyst, I had to suspend notions of adequacy, value, success, and so on, in examining their accounts. As an analyst, I was interested solely in their methods of making sense for me, not in their psychological state. As a "regular" person, I hope the procedure disturbed them no more than they said it did.

The methods used for the analysis of the data were as follows. After transcribing the tapes of the original conversation as well as of my interviews with the participants, I read and re-read the transcripts, periodically listening again to the tapes to re-capture intonations. By juxtaposing the participants' comments about their interaction against each other and against the original conversation, I attempted to determine how the doctor and patient understood one another, how the doctor formulated his diagnosis, and how both participants established the task as competently and successfully accomplished.

The juxtaposition of the original conversation and the two interviews relating to it was not as simple as I had expected. In the first place, the transcripts derived from one complete session ranged from twenty to forty-five pages. The length alone precluded laying out the material from one interview all at the same time. In the second place, as mentioned earlier, the participants' comments were not in the same order as the original transaction and comments on a given topic chosen from the original conversation were not said all at once in the interview. So I had to search the data to find answers to match up with my questions. In the third place, my own understandings of what was occurring depended on reading a given section in light of what had gone before and what had come later. The juxtaposition was therefore not
only horizontal, but vertical as well. All of this is to say that "juxtaposition" is a gloss for a great deal of painstaking labor. It is also to say that analysis was occurring already during the time I was preparing the data for analysis.

Several months were passed in examining each set of interviews and writing detailed notes concerning what I believed to be operative at each step. I worked back and forth between the data, the particulars of my early analysis, and the writings of other investigators until I found ways to present a rational account of the proceedings. So-called extraneous factors also helped shape the outcome—factors such as time, energy, and practical judgments about where to put an essentially arbitrary boundary around the unbounded possibilities of what could be done with the data.

In conclusion, the various features of the activity involved in the actual accomplishment of this study may be reviewed from the standpoint of Garfinkel's depiction of professional sociological inquiry (1967:96-99).

1. During an interview, an investigator generally finds himself encountering situations whose outcomes are unknown. That is, the outcomes are not clearly specifiable before taking the action intended to actualize them. All the strategies described earlier as attempts to preserve the integrity of the interviewing situation—for example, refraining from certain lines of questioning in the hopes of avoiding embarrassment, or cutting the interview short in the hope of avoiding excessive intrusion on the participants' other obligations—illustrates this feature of a sociological inquiry. The outcome of such strategies
was unknown beforehand in that any specific interview might not be purged of all the embarrassing questions or might not be stopped in time to prevent intrusion. Furthermore, the overall outcome of the strategies vis-à-vis the goals of the study could not be specified prior to undertaking them. The adequacy of the questions and answers that remained as part of each interview had to be settled at the time of the analysis.

2. Although a future state of affairs may be clearly envisioned by the investigator, the diverse ways of realizing that future state are generally unelaborated. Given, for example, the envisioned future of having secured the permission of the clinics' personnel, doctors, and patients to carry out the project, the steps I narrated earlier as necessary for gaining those permissions were not pre-programmed, but rather were improvised in the face of the circumstances I met.

3. Frequently, an investigator takes some action and upon encountering its consequence, searches that action for its decided character. In describing the course of my interviews, I referred to decisions made concerning when to risk the pursuit of various lines of questioning. But the bases for these decisions were often identified by me after the fact as I examined the interviews, and not before or during the conversations.

4. Though an investigator may attempt to choose among various possible courses of action on the basis of their predicted consequences, he frequently cannot anticipate their consequences and must await his actual involvement to learn them. For instance, I did not expect that my attempt to observe facial expressions and physical gesturing would
involve me in the interaction between the doctor and patient. This discovery was made only in the doing and then necessitated an alteration in my plans.

5. It may happen that an investigator meets some circumstance, finds it desirable, and then counts it as the goal towards which he was moving all along. Had I reported that my sample consisted of eleven permanent, full-staff doctors without recording the situation under which such a number was reached, it would have appeared that from the start, "eleven" had been seen as the ideal and intended size.

6. The goal of an investigation is often progressively defined as the researcher follows a course of action whose goal on any single occasion of action is not distinctly seen. These situations result from a lack of information on the part of the investigator. Usually, he cannot even assess the effect of that ignorance on the accomplishment of his activities. In the case of my study, I intended to discover processes of communication between doctor and patient. But the exact shape the result would take—that is, what specific themes I would find in the data—could not be known in advance of gathering the data. Therefore, whether any particular series of actions during the period of observation or interviewing would tend to reveal or obscure such themes could not be calculated at the time. The goals eventually settled on—i.e. the material discussed in the following four chapters—had to be formulated finally on the basis of what I had in hand.

7. Because the information on the basis of which an investigator chooses his strategies is seldom codified, estimates of success or failure do not have the features appropriate to a statistical concept
of probability. All the strategies utilized in gaining access and in negotiating the interviews were elected on the basis of situationally specific cues described in the earlier sections of this chapter, and not on the basis of mathematical calculations.

Added to these features, Garfinkel points out that investigators act under the following additional conditions:

. . . that some action must be taken; that the action must be taken by a time and in pace, duration, and phasing that is coordinate with the actions of others; that the risks of unfavorable outcomes must somehow be managed; that the actions taken and their products will be subject to review by others and must be justified to them; that the elections of courses of action and the resultant outcome must be justified within the procedures of "reasonable" review; and that the entire process must occur within the conditions of, and with his motivated compliance to, corporately organized activity (1967: 99).

As has been mentioned at various points throughout this chapter, what these features mean for the present study is that the project had to be coordinated with and justified in accordance to requirements of the participants, the specifications of the clinics' operations, the stipulations of the granting agencies, and in addition, the demands of my advisors at the university. As Garfinkel proposes, it is in light of all these characterizing features that the findings of this and any other sociological investigation are recommended as warranted.

In this chapter I have recounted how the project began, evolved, and ended. The ideal plan formulated at the outset turned out to be more of a position to bargain from than a blue print to be executed. The actual accomplished plan was what resulted from the bargain struck with the sundry contingencies of the setting and the varied requirements of the participants.
CHAPTER THREE

THE SETTING

As was indicated in the last chapter, the setting for the research into processes of communication between doctor and patient was provided by the five public health clinics in Harris County, Texas. This chapter concerns the characterizing features of these clinics with special attention to the fact that these features are made available as features through somebody's characterization. That is, the scenes at the clinics took on different senses for me depending on whether they were being seen against a background of experience with middle-class clinics, with descriptions provided by the staff, with narratives given by the patients, or with disclosures made by the doctors. After ethnographic details of the clinic have been depicted, I shall present the features made observable by these various viewpoints and the practices whereby that availability was accomplished.

Ethnographic Details of the Clinics

Fairview. Fairview Clinic is situated on a block of its own in the midst of a residential area inhabited primarily by blacks. It is housed in a brick building it shares with several other public health services. These other departments are essentially separate except for the fact that a few of their allotted rooms are made available to the medical clinic when scheduling permits such use.

The waiting room is the first room encountered upon entering the
clinic. There are sixteen chairs available, placed in rows. The walls are bare except for several signs that admonish and instruct the patients: "No Loitering;" "No Alcoholic Beverages on Premises;" "All patients must be registered at 8:30. Only emergencies are registered later." The sign posted on the door so as to be read when leaving reads: "Stop! Do you have your appointment slip? Do you have your medicine?" Scattered political folders advertising Dick Gottlieb's qualifications to be mayor are the only other reading material there.

The room is full of noise and movement due not only to the conversations of the waiting patients but also to the activity of the staff working in a partially enclosed area at one end of the room. Here the patients notify the receptionist of their arrival, return their charts after seeing the doctor, and make new appointments. In the same very small area, the cashier does her work as do those who need to use the telephone, the Xerox machine, the microfiche viewer, the general files, or the teletype connected to Miller Hospital.

(Since Miller Hospital is referred to numerous times throughout the rest of the study, a few remarks about it will be made here. Miller is the county hospital. It operates financially on a sliding scale so that patients with very little income use Miller as their hospital. Before the six public health clinics were established, the outpatient clinic at Miller was the primary facility for the poor. It was and is inconvenient for them because, in the first place, its location is quite distant from the areas of the city where many of the poor live. In the second place, it is very crowded. A patient must register by 7:30 a.m. on the day he wishes to be seen and then wait his turn which may not
come until 4:00 p.m. Even with the neighborhood public health clinics in operation, Miller is still used for specialized tests, for inpatient care, and for emergency treatment.)

Across the hall, a larger room provides more waiting space and has several vending machines. The pharmacy is situated at the far end. Beyond this area lie several offices and examining rooms.

The other side of this second waiting area opens into the office where the nutritionist counsels with patients regarding diets for diabetes, weight-reduction, and general health. Interviewers who gather information required to establish a patient's eligibility for the clinic's services also use this office. They were introduced to me as "the ladies who ask the patients all the nasty questions and make them mad." As a result of these interviews, patients are given a card with an identifying number plus a code indicating the amount they must pay for medicine and for the physician's care. The fees are based on amount of income and the size of the family. The fee may be zero. Patients whose income relative to number of dependents reaches a certain level are not eligible to be treated at the clinic after one initial visit. There are also certain requirements related to residence. (In Appendix B, the schedule of payments and the residency requirements are listed.) These interviews for eligibility are repeated periodically in case any changes have occurred in the patient's circumstances.

A laboratory for routine tests and the shelves storing all the patients' charts are located next to this office. Across the hall are other offices, examining rooms, and the x-ray room. The hall itself contains several chairs for patients next in line to see the doctors.
and, at the far end, an area where the nurses measure the patients' weight, temperature, and blood pressure.

There are several additional staff members and services at the clinic. A social worker serves Fairhaven on a part-time basis. A driver provides transportation to and from Fairhaven or to and from Miller for patients who so request. And there are security officers working in shifts.

**Greenland.** Greenland Clinic is located in a business district in a building barely distinguishable from the stores that surround it. Although the neighborhoods in the area are predominantly black, many white people also live nearby and frequent the clinic. From the outside, it appears quite small, but inside it stretches into an extensive array of offices, waiting areas, and examining rooms. The entrance opens into the first waiting room where eighteen chairs are arranged in various constellations around the walls and tables. A color television plays loudly and continually. The room is decorated with a growing green plant, a framed print, and a poster advocating the merits of hearty, healthful breakfasts. Pamphlets are available describing the symptoms of cancer. Also there are some which set forth the social services of various agencies. Several signs are on display: "To all patients. This is your clinic. We strive to please. If for any reason to your knowledge the services you have received are not satisfactory, please feel free to report these to the administrator of this clinic;" "All visitors please stop at the receptionist's desk before entering any departments within the center;" "Quiet Please."

A glass partition separates the waiting area from a large room
where the receptionists and filed records are housed. Just outside is the pharmacy. The area utilized for the interviews establishing eligibility borders the waiting room and is only partially enclosed. Along the hallway that stretches to the back of the clinic are offices for the secretaries, the mental health worker, the nutritionist, the lab technician, and the x-ray technician.

At the end, the hall opens into a small waiting area. Here the patients wait to have their weight, temperature, and blood pressure measured in a nearby room and following this procedure, move to a larger area to wait their turn with the doctor. Also waiting here are patients waiting on tests, family members waiting on patients, and patients waiting on medicine. Examining rooms and the doctors' office surround this third waiting room.

Like Fairview, Greenland has a security guard. Unlike Fairview, the transportation service is utilized only secondarily for bringing in patients. It is primarily involved with such errands as carrying supplies and tending to the business of the payroll. The administrative head of the clinic expressed regret at this state of affairs and spoke of her plan to work out a way to share vehicles with other agencies in the community.

The clinic is crowded, congested, and noisy. To walk through it requires continual stepping over and around. Business has to be conducted in the midst of where more business is being conducted. Fortunately, additional space will soon be available from the building next to Greenland.

Woodhaven. Woodhaven Clinic is in a residential setting and
treats about equal numbers of black patients and white patients as well as some Mexican-Americans. The large and sprawling building was once a church. In fact, eleven rows of pews provide the seating for the waiting room. The space occupied by the medical records and pharmacy opens into this room as does the receptionist's booth. At the back, three interviewers work with the patients on eligibility. Just outside is a small room where the nurses measure the patients' blood pressure, weight, and temperature. On down the hall are the examining rooms.

A separate wing of the building houses the various adjunct services offered by the clinic. As needed, patients are referred to these by their doctor. A counselor in home management advises the patients on budgeting and dieting. For educational material, she draws on pamphlets supplied by such places as the milk companies and the wildlife commission. A large poster depicts milk and meat as "A smart buy" and soft drinks and potato chips as "A not-so-smart buy." There are two x-ray technicians. A mental health clinic is staffed by two psychiatrists for a few hours a week plus a counselor who handles lesser problems and checks on medication. A worker in social service helps put the patients in contact with other agencies such as welfare and food stamps. Finally, there is an office of public health whose nurses and paramedical staff go to the home of a patient to administer injections and ascertain if medicine is being taken correctly. When the patients permit, the nurse will examine their cabinets and throw away outdated drugs.

Hilltop. Hilltop Clinic shares with other agencies a very large two-storied building that resembles a school. The building and grounds cover an entire block of a residential area inhabited primarily by
Mexican-Americans. The medical clinic is located on the second floor as is also the city health clinic with which it is sometimes confused. Just inside the entrance is a glass-enclosed area for eligibility and reception. Beyond this office extends a large waiting room with chairs for thirty-five patients. The pharmacy opens out into the far end of the waiting room. A small hallway leading from the waiting room to the administrative offices serves as the place where the social worker does her counseling. The laboratory for routine testing is further down the hall. A nutritionist is available once a week, and transportation to the clinic is available when the driver is not involved with carting supplies.

Hilltop does not have an official security guard. The administrative head explained that it has not been necessary to hire a guard because the clinic is not in an isolated area, personnel from other agencies in the building are nearby, Hilltop does not handle any money, and so far no drugs have been taken. She added that there is an attendant "who sort of acts as security officer by hanging around the parking lot" as long as any part of the facility is open.

One very large room serves as the site for all the activity between the patients and the nurses and doctors. Across the back, curtains are hung in such a way as to create three or four separate examining areas. Three desks are arranged in front of these curtains for the doctors to use during their interviews with the patients. On the other side of the room, the nurses work in two areas, one for records, appointments, and orders, the other for the procedures that ready the patients to see the doctor. Along both side walls are chairs for the patients
waiting between the various stages.

Piney Point. Piney Point Clinic has a recently constructed building located in a business district but set off to itself. The waiting room extends across the front of the clinic. Signs instruct the patients as follows: "No Smoking;" "Please do not eat or drink in this area;" "Attention. Patients must bring in all medicines on every clinic visit." Chairs are provided for sixteen patients and are arranged in rows. Two prints decorate the walls. A glass-enclosed office for reception and record-keeping lines the hallway connecting the waiting room to the rest of the clinic.

The back of the clinic is divided into a number of small examining rooms and offices. Staff members are few and, as the administrative head at Piney Point explained, in addition to her other responsibilities, she serves as nutritionist and social worker. She said that those who work with the medical records, the finances, and the interviewing for eligibility also learn one another's procedures in order to be able to serve as substitutes in those capacities when necessary. Transportation is available for patients needing rides to the clinic or to Miller.

The clinics are open eight hours a day, on some days from 8:30 a.m. until 4:30 p.m., on others from 12:30 p.m. until 8:30 p.m. Doctors see from twenty to forty patients a day depending on the number of emergencies and the number of doctors on duty. The pace, even so, is generally relaxed and the relations among the staff informal.

The Multiple Realities of the Clinics

Any social scene derives its meaning from the imputations made about it by those who are involved in it or who are observing it. Since
these imputations differ, depending on the viewer's purposes, knowledge, point of reference, and so on, we can speak of a social scene as having multiple realities. Consequently, the activities of the public health clinics—being eminently social scenes—participated in this multiplicity and were seen as different realities according to whose scheme of interpretation was being applied. These differences, and what difference they make, are detailed in the pages that follow.

My own point of reference for viewing the clinics' procedures was based on my experience with clinics that serve the middle-class. Such clinics typically treat only one (small) area of the body at a time, provide no social services on the premises, cultivate an atmosphere of quiet and formality, and carry on all medical and financial business behind closed doors. As a result of my using this typification as the standard for comparison, two matters were especially remarkable to me during the early period of observation at the public health clinics. First, the activity looked disorganized. Second, certain features of the clinics and of the staff's interaction with the patients struck me as possibly offensive to the patients. I will discuss each of these in turn with particular interest in pointing out that what impresses an observer may have an entirely different sense to participants.

As I watched the multitudinous activities occurring all at once at each clinic, no inherent orderly arrangement was readily apparent, for I was seeing only the middle of things. Where they began, where they were going, how they fit together, and for what purposes they were done were unavailable to me as an onlooker. Not until those involved in the activity began to tell me their stories did the movements take on a
specific sense.

The setting was rendered organized through the accounts of the staff members. By means of two practices—establishing sequence and imputing purpose—they formulated for me the kind of background knowledge necessary for me to see the activities as orderly and routine procedures. By "establishing sequence" I mean that the staff members broke up the simultaneity of the appearances into discrete, successive events. They physically led me from one site of action to another, breaking up the simultaneity by this very movement, and establishing orderly sequence by recounting as we went the retrospective-prospective connections between the sites. For example, I was taken to the room where the interviews are conducted to determine eligibility and was told that "before the patients come in here, they already have turned their appointment slips in at the desk and then when their time comes up, they come in here if it's their first appointment at the clinic. Then after they talk to the ladies in here, they go back out and wait for the nurses to weigh 'em and everything."

The activity was also rendered organized by the imputation of purpose. This imputation was done first of all by the staff's descriptions of functions at each site. In this way, what had appeared to be an aimless, milling crowd took on the shape of a group of patients waiting for prescriptions to be filled. What had appeared to be a small cluster of the passed-over and probably lost changed into a line of patients waiting for tests to be run. What had appeared to be a labyrinthine maze of rooms into which people regularly disappeared became an ordered collection of sites where varied services are offered to the
patients. What had appeared to be haphazard alternations on the part of the staff between flurried activity and languorous inactivity was transformed into a periodicity imposed by some particular phase of the current task at hand.

Imputation of purpose was also accomplished on a grander scale. That is, the staff members embedded each event in an overriding purpose schema. For example, the functions of separate activities such as using the teletype connected to Miller to determine if a patient already had an eligibility classification there (thus saving him from repeating the process at the clinic), or having the varied positions of nutritionist, social worker, x-ray technician, and transportation as part of the staff—the functions of these separate activities were located within the larger design of "providing quality care at the neighborhood level." By invoking this notion, the staff members could describe each of the various events and services as aimed at "letting the patients get good care and get it all in one place without too much hassle." Through their accounts, then, the staff members organized the procedures such that I now was provided with some alternatives to the typifications of the middle-class, specialized clinic through which to make sense of the setting.

These two practices—establishing sequence and imputing purpose—were also features of the patients' accounts whereby the organization of the clinic was made observable. There are some differences, however, in the way this work was done. Three examples will be given before these differences are discussed.

The first example is drawn from the interview with Ms. Vaughn.
I: What happens when you first come to the clinic (Woodhaven)? Like today, where did you go when you first came in?

Pt: When you first come in, there's a little cage you go to. I put my card in and then she gives me my card back and I go over across to the next window and get my chart. She takes my chart, puts it in the box, then gives me this little piece of paper here and uh then I sit down and I wait until they call my name. When they call my name, I go to that first door out there and get my temperature and my blood pressure and my weight and my height. And then after that I go back to the waiting room and wait till they call me to see the doctor. And then they call me to see the doctor.

Most patients gave a somewhat briefer version. The excerpt from the interview with Ms. Brown at Fairview is typical:

I: What happens when you first come into the clinic? Like today, when you walked, when you first get here, what all do you have to do?

Pt: Well uh, first you turn your appointment slip in at the desk, then you sit down and wait till they comes to take your temperature and blood test and weigh you, and then after they weigh you, well you sit down and wait about five or ten minutes and then the doctors call you and see you.

A few of the patients telescoped the events further by assigning a great deal to the category of things that are essentially not their responsibility. In the following response by Mr. Rodriguez, I have underlined the point at which this categorization occurred.

I: What is the procedure here in the clinic (Hilltop) when you first come in the mornings? What do you have to do when you walk in the door?

Pt: Well, just come in the front up to, to the desk. Hand in my, my appointment slip to them and then from there on they take care of the rest of it. Get my shot and then, then I don't, I don't stay here that long, you know. Take a blood test, see the doctor.

These examples illustrate the two practices used by the patients in organizing the setting. As with the staff members, the first practice
consists in establishing sequence. Whereas the staff members broke up the simultaneity of appearances into discrete and orderly events by leading me from place to place throughout the clinic and describing the before-and-after connections between them, the patients established sequence by setting up a nucleus around which the activity revolved. That is, when a patient gave his account of his time at the clinic, he took as his focus his own part in the proceedings and presented it as a succession of steps. (I did this, and then this, and then this.) He told only what had happened to him, leaving unmentioned the movements of the other patients and the actions of all staff members not directly, currently, and noticeably related to him. The actions of even those staff members who had interacted with him were recounted only with respect to his focus. What they were doing behind the scenes with his appointment slip or vital measurements was not a matter for reporting. That was their business. As Mr. Rodríguez said, "... they take care of the rest of it."

With the patients, the second practice—imputing purpose—did not take the form of detailing the functions of each step or invoking an overriding grand schema. Rather, as with the first practice, the patients kept the focus sharp, narrow, and immediate. They presented the steps as moving toward the goal of seeing the doctor. All the activity led there, all the descriptions stopped there. So, through the patients' accounts, what had appeared to me as an obstacle course whose victors were finally allowed to leave the premises turned into a series of familiar and easily followed steps leading to a conference with the doctor.
The other matter especially remarkable to me as an observer working at the beginning with a set of relevancies different from the participants' concerned a constellation of features at the clinics that I thought the patients probably resented. For example, the signs prohibiting alcohol or loitering or eating, or even the ones urging "Quiet Please" seemed likely to generate offense. Furthermore, the presence of the armed and uniformed guards might be construed as an affront. One of the officers' descriptions of the task underscored my impression. Pointing to his badge designating his position as "security officer," I had the following exchange with him:

I: What are you supposed to keep secure?

Officer: Well, we have medicine out here and also the cash register, and besides, you wouldn't believe some of the fracases and disturbances that go on around here. Mostly we're here for discipline purposes. Just seeing us here makes the people behave, you know, keeps them in line.

The lack of privacy also struck me as assuredly bothersome and probably insulting. At Hilltop, the patient's conversation with his doctor takes place in an open area where other patients and personnel are in close proximity. Woodhaven has separate rooms for these conversations, but the doors are left open into a hallway which stays full of people. In the other three clinics, the exchange between the doctor and patient occurs in private. Still in those clinics as at Hilltop and Woodhaven, a good deal of personal business is discussed at the receptionist's desk within the hearing of many.

Finally, the general tenor of the ways of relating to the patients appeared to me to be very similar to the ways of relating to
children and seemed to me to be paternalistic. Patients were frequently addressed by their first names and by terms of endearment such as "honey" or "darlin'." They were also patted and cajoled. Explanations were made in painstaking detail. For example, one of the patients was being referred to Miller for testing. The nurse made a copy of his chart, put it into an envelope along with the notification of his appointment, and handed it to him with the following instructions:

Nurse: Now there's a piece of paper in here with some writing on it that's supposed to be read. So you hand the whole thing to them out there at Miller.

Moreover, patients were asked to bring their bottles of medicine with them in a paper sack so that the doctor could "see for himself" if the medicine was being taken correctly (or at all).

These features so salient against the background of middle-class clinics were never remarked upon by the patients either during our interviews or during the times we talked informally before and after our recorded sessions. The guards, the signs, and the lack of privacy were never mentioned. The familiarity as well as the detailed and frequently reiterated instructions were taken as indications of care and concern. Again, we are reminded of the ambiguous character of events and that behavior derives its sense from the particular context supplied to it by a particular viewer. Several examples will be given to show the character of the responses patients gave when asked to tell me their impressions of the clinics. The first example comes from the interview with Ms. Granado at Woodhaven:

I: What do you think of the clinic?

Pt: I think it's wonderful. I think it's a wonderful clinic. The first time I came I didn't know it was here. I found
out through the health department. I came here and everybody was just so sweet and so wonderful. I tell you, I couldn't help myself, I cried with joy because I didn't expect to find such a place as this, you know. And uh I waited in time and uh, you know, you don't get tired of waiting because they keep you going around, you know, taking you to here, go there. It's just something wonderful. . . . The doctors are real kind. The nurses are just beautiful, just wonderful persons. I been to Miller before. Sometimes it's too crowded. . . . It took us all day. This place here is just wonderful. First time I came it was raining real hard and uh I had to wait outside for my daughter to come pick me up and uh a nurse went out there and said uh, "Ms. Granado, whatcha doin' out here? Come inside, we don't want you to get sick on us." She was just so sweet. . . . I cried with joy about how wonderful these people are.

In the second example, Ms. Flowers spoke of Fairview and of her doctor, Dr. Ferguson:

I: Tell me a little about this clinic.

Pt: Aw, I think it's a nice place to come (unintelligible) you know for our neighborhood. It's really convenient for us, you know, that it's out here because really I hadn't, you know, I wasn't familiar with, I had heard about it and everything but I just already you know uh going to Miller so I had (unintelligible) and I find that mo., it's more uh convenient for me to come to this clinic and uh even it helps me financially (laugh). You know, not so much gas and everything. I can just walk around the corner to this clinic and the doctors and everyone is so nice over here. And it, you know, they have so, they have patience with you and they have take out alot of time. And then I especially like my doctor because, you know, he seem to be concerned about his patients. And it's not like, you know even some of the doctors that I went to and paid, you know if you ah need to ask a question, some of 'em just sit and look at you. But he tells you, you know, he try to give you an answer.

Ms. Franklin's comment on Greenland is the third example:

I: Tell me what you think of the clinic.

Pt: It's nice. It's alot better than Miller.
I: How?

Pt: You don't have to wait as long. And the doctors aren't as, as uh, as im., as impersonal. I mean the doctor here'll talk to you. The doctors at Miller, they, it doesn't, they don't think you have too much sense. I guess they think you're stupid. And uh I just didn't like going out there.

I: How could you tell that they thought you were stupid?

Pt: They, they wouldn't, they wouldn't sit down and tell you what was wrong. They'd, they'd uh, they gave you a sugar-coated diagnosis and then write in your report what's really wrong. And at least Dr. Glass, what he writes in the report is what he tells me.

The fourth example is taken from the interview with Ms. Vaughn at Woodhaven:

I: What are some of the things that you notice about the clinic?

Pt: Well it's, it's (unintelligible) the time I been comin' here, I mean, the peoples all have very good personalities. I like 'em all, I, uh, I be honest, uh a few in Miller sometime they be tired or somethin', they didn't have as quite as sweet a personality as the staff here. But uh all of the employees here seem to have a good personality all the time. That's really wonderful. You know, it make you good when you, this is the way I meant, uh, we're disability social security, and when you know you can't afford somewhere else, and then you find someone with a good personality when you do go, it (unintelligible) oh man it's that way because you know you gotta pay and he's nice to ya. But you, they know you can't pay and they still nice to you, it make you feel like you're still a human bein', uh, you know, it gives you a lift. But when they're mean to you, sometime it breaks your heart, specially when you're sick and you can't do no better. And so far I've found all the employees here is very nice. If you'll see me out there, you'll see 'em call me by my name.

In the final example, Mr. Martinez speaks of Hilltop:

I: Could you tell me a little about the clinic?

Pt: Well I been to many doctors. I wouldn't have too many, maybe five or six. And I find I get better
treatment here than the doctors that you go in the private. For one reason or another when they take you through a routine that whatever you may need or you're needed and they'll see exactly. Like for instance, I have a blood pressure since 1967. Been going with lot of doctors, I mean four, five or maybe more. They give you pill, they prescribe you something sitting on the desk oh about three to four feet away from you and you take off, pay up at the front, and forget about it. You come back, say, says come back in about three weeks, two weeks. Come back, give you another one, the same thing. Go back again. You say, "Listen now, I want, ah, I might have ulcers, I might have this."

They run to a special laboratory and they charge you $15 or $20. And takes off and come back two or three weeks later. You want him to do, you request what you want him to do. In the clinic, they'll tell you what to do--walk here, go get your x-ray, go get your blood test, bring this proof, don't eat that, don't eat that, and that to me is a great thing that is in this clinic.

The features of the clinics mentioned most frequently by the patients were convenience and concern. Their standard of comparison was usually Miller. Besides the difficulties imposed by the overly long waiting periods, the patients do not like Miller because the doctors there are "in a rush to get you out" and "awful nasty to you." But even those patients who cited their experience with private doctors as a standard of comparison preferred the neighborhood clinic because treatment there was more thorough and concern more evident.

Thus, the behavior I had seen as paternalistic was taken by the patients as considerate. Being addressed by first name indicates caring, not lack of respect. As Ms. Vaughn put it, "I've found all the employees here is very nice. If you'll see me out there, you'll see 'em call me by my name." Being instructed in detail indicates caring, not exasperation. As Mr. Martinez put it, "In the clinic, they'll tell you what to do--walk here, go get your x-ray, go get your blood test ... don't eat
that, and that to me is a great thing that is in this clinic." And we
saw from Ms. Granado, even being told to come in our of the rain indi-
cates caring, not an imputation that she does not have the sense to
come in out of the rain.

The meaning of the other features I had noted was also altered
by the patients' remarks. That is, the patients did not complain about
a lack of privacy. Rather, as we noted in the last chapter, they fre-
quently made efforts to assure me that my extra presence had not made
them uncomfortable by saying they were accustomed to having people
around, i.e. to having several doctors and nurses caring for them at
once. Given this context of the clinic as a place providing attention,
solicitude, and general watchfulness, I began to see the presence of the
prohibitive signs and the armed guards in a different light. These too
could be taken as evidence of concern in that they made the clinics
secure and orderly.

The point to stress in the discussion so far is that evaluating
the proceedings and interactions at the clinics from the standpoint of
a middle-class conception of proper form may be an instructive compari-
son but can lead to erroneous conclusions concerning the opinions of the
clientele. Some research in these settings, such as that done by the
granting agencies, rests entirely on the impressions of the observer
and/or on interviews with the staff. That procedure can result in seri-
ous misconceptions when statements are then made about what the atti-
tudes and feelings of the patients "must" be. As was pointed out ear-
lier, for example, behavior that may appear paternalistic to an outside
observer is provided with an entirely different sense when described by
the recipients of that behavior. Suppose a questionnaire had been administered and had contained the item "Does the staff address you by your given name?" as an attempt to measure the general tenor of the interactions. Since the questionnaire does not allow the researcher to use the patients' scheme of interpretation to explicate the responses, he must use his own. From the standpoint of middle-class expectancies, he would likely count a "yes" to such a question as indicative of a lack of respect on the part of the staff. In this way, he would take a feature of the clinics that to the patients shows personal concern and turn it into a sign of debasement.

Or again, consider the efforts of the clinics' own staff to discover the patients' views. Following standard professional sociological practice, the staff members pass out fixed-choice questionnaires to the patients with such items as "Do you have to wait too long?" Since this procedure leaves out of account the patients' basis of judgment, those who analyze the responses must rely on their own best guesses as to what the answers mean. A "no" answer may be construed as indicating that the waiting period is satisfactory when all the patient meant was that, relative to the 7:30–4:00 wait at Miller, the sometimes three hour wait at the clinic is not too long. Thus, action founded on the responses to these questionnaires and intended to be in accord with the desires of the patients can run far afield when the specific sense of these responses is unknown.

We have looked at the realities of the clinics as provided by the standpoint of an outside observer, by the staff, and by the patients. It remains to learn about the setting from the doctors. After presenting
their characterizations of the patients and clinic, I will indicate the significance these characterizations have for the way the doctors do their work of understanding the patients' talk, making diagnoses, and establishing the rational character of their actions.

**Fairview.** Three doctors at Fairview participated in the study—Dr. Branch, Dr. Compton, and Dr. Ferguson. Dr. Branch described the clinic as treating primarily the chronic conditions of the elderly and secondarily, acute episodic or self-limiting cases. He has a private practice in addition to his work at the clinic and reported "no difference" between the two practices. The problems he noted at Fairview were the inadequate space and the length of the waiting period. Dr. Compton categorized the cases in the same way as Dr. Branch with the additional comment that "We don't get too much in the way of interesting work-up type of things, like a lesion in the chest or something like that."

Dr. Ferguson characterized his work at the clinic as being "sort of a hassle." Two causes were cited, the bureaucracy and the patients. His discussion of the problems deriving from the organization of the clinic are as follows:

Dr: The uh bureaucracy, the system itself, is just typical of any government-run medical system. Uh, it's such that, for example, Dr. Thomas who was here before, uh, Dr. Thomas and I worked with two treatment rooms and yet for thirteen months had only one light switch so that in order to examine the eyes of a person, which is routine on any physical, I had to go next door, interrupt him, put him in the dark, go do my exam, and finish, then go back and turn the lights back on for him. So this was for thirteen months. Or, for example, it took uh nearly ten months to get just uh the simple thing that you look in the ears and eyes with (unintelligible) so that we had to swap those
back for like nine or ten months. . . . And a lot of the reasons that it, that it goes on is because it's two different completely different chains of command in the clinic. There's uh, the medical and then there's everybody else. And the chains of commands don't meet until you reach the top of the Harris County Hospital District Board of Managers who hardly know that the clinics even exist. In other words, the physician here has authority over no one in the clinic. Their authority goes up to non-medical personnel and as a consequence what is of importance to them and what's gonna determine whether they keep their job and whether they're promoted and what not, is that whether or not they do the things that their bosses want done. And there's, there's simply no way to exert any kind of pressure to get things that were having to do with patient care and with uh, you know, medical things that were never done.

Regarding the patients, he said:

Dr: By and large, when you're treating people who are poor which is the population we tend to here, by and large you're treating people who are not very intelligent and as a consequence, two things happen: one is, they really have no idea as to when they should come in and when they shouldn't. So they come in at inappropriate times and it works both ways. They don't come in for things they should and they do come in for things that no middle-class person in his right mind would come to the doctor for. In the second place, it's, if you treat someone who understands the problem you're treating and who understands what you've done, then there's much greater appreciation. But if the person really doesn't understand what's going on, what you've done for him or haven't done for him, you know, then there's just not as much appreciation naturally and there's just not as much uh feeling of having done something on the part of the doctor.

In Dr. Ferguson's estimation, these two problems generate a high degree of frustration and account for the difficulty in keeping doctors as members of the staff for more than a short time.

Greenland. Dr. Glass's characterization of the kinds of cases predominant at Greenland was quite different from the one given by Dr. Branch and Dr. Compton at Fairview. According to Dr. Glass, most of the
patients at the clinic are female, divorced, poor, overweight, and depressed. Unlike Dr. Branch, he reported his work at the clinic as dissimilar to his work in private practice. His patients at the clinic are "so glad to be able to have a doctor they can call their own" that their show of gratitude "makes you feel good you're able to help." In his private practice, he has the impression that the patients think "you're only doing it 'cause you're gonna make a buck, and you become like any other business man." His enjoyment of the work at the clinic, however, has begun to pale due to the tensions at Greenland. The source of these tensions was described in terms similar to Dr. Ferguson's remarks about bureaucracy. According to Dr. Glass, the formal division of authority results in the nurses' effectively "running the clinic so that the doctors are low on the totem pole." Particularly irksome is the fact that the nurses tell him on any given day which rooms are his for the day and which ones belong to the other doctors. He said this state of affairs "blows my mind."

Dr. Hunter did not share Dr. Glass's depiction of the typical patient at Greenland. In fact, he said there is no typical case, that the clinic "gets all types, just like Miller, everything walks in there walks in here." His comments on his feelings about working at the clinic are as follows:

Dr: Oh it's nice. I enjoy it. Have alot of fun out of the patients. But they, they like the, the, the friendliness that you do. And you really have to, you know, take time out to, take time out to explain things to them and that's what a private physician would do in his own office. And that's the attitude we're hoping that we can get to them, is that there's a desire for them, you know, to have the best of care and also that there's the opportunity of seeing the same, uh seeing that they have in a private doctor's office.
Dr. Hunter's discussion of the constraints imposed by the bureaucracy had a different focus than Dr. Ferguson's and Dr. Glass's. For one thing, he complained of the time consumed by filling out required forms and papers and of his unfruitful efforts to convince the "higher-ups" that any gains derived from such complete records were surely cancelled by the fact that the record-keeping "slowed everything down." His second comment on bureaucratic troubles concerned certain policies regarding the use of tests and of antibiotics. He said that in private practice, he had worked with people for so long who could not afford tests that he had come to rely on his own judgment about their needs.

Dr: But the book says here that if they come in with a cold, I'm supposed to have a chest x-ray done. They come in with a busted arm, I'm supposed to x-ray it. I could tell by listening to the chest or asking where the pain was whether they needed an x-ray or not.

Regarding the policy restricting the use of antibiotics to cases where bacteria have been shown to be present through laboratory tests, he said:

Dr: The way I feel about it, I'd rather be on the safe side. Just like there's infectious diarhrea and non-infectious diarhrea and a baby comes in and you think it's the non-infectious diarhrea and you treat him about five days for that and he doesn't get any better and you see him again and he's dried up like a little knot and you find out it was the infectious kind and maybe it's gone too long and you'll lose that baby. So when I see diarhrea, I give antibiotics. I figure it doesn't do any harm, and I figure it's easier to stay out of trouble than to get out of trouble.2

In light of these bureaucratic troubles and the additional matter of low salaries, Dr. Hunter stated that the only compensations for "working in a hole like this" is the enjoyment from helping the people in the community.
Woodhaven. At Woodhaven three doctors were involved in the study—Dr. Henry, Dr. Dudley, and Dr. Hart. Dr. Henry stated that because the clinic serves a population of low-income, most of his patients are "people who are poorly adjusted, people who are retarded and can't fit into life." In his opinion, the resultant emotional problems give rise to a host of physical ills that run the gamut from "nervous stomach" to arthritis. His frustration regarding what faces him at the clinic is that all his medical measures are merely stop-gap and do not alleviate the "psychic problems" from which the physical problems stem.

Unlike Dr. Henry, Dr. Dudley described the patients at Woodhaven as being "of all types, the same as you get in any doctor's office anywhere." Work at the clinic differs from work in private practice in that the clinic offers more services to the patient. The drawbacks are personal. That is, the salary is low and the nature of the "political set-up" is such that "somebody could get mad and shut down the program and I'd be gone tomorrow."

Dr. Hart also depicted the cases at Woodhaven as being varied: "We get patients of every type, age, race you can imagine. You get every possible illness." He noted two differences between private practice and the clinic. First, he said,

Dr: There's the matter of race. Being a black doctor, I saw 99 and 9/10 percent black patients. Here it's evenly divided with 50% white, 10% Merican-American, 40% colored or black. The large number of whites that come here is very surprising to me as an individual. I never dreamed a large number of whites would patronize a clinic black staffed, black-run, and only has one white nurse every once in a while. . . . And the attitude of the patients is very surprising. I never expected them to act as nice as they do frankly. Sometimes people can be very ugly and rude to you, frankly. But these people never are. They are very, very nice.
The second difference is that in private practice, patients called his home at night. "But," he said, "when I finish at the clinic in the evenings, I'm through. Nobody bothers me."

Hilltop. Dr. Scott at Hilltop centered his comments around his frustrations at trying to practice community medicine under the present arrangement and policies. He described himself as "compulsive" in his desire to do a "complete and competent job" and as a result, orders numbers of tests on each patient.

Dr: I am not willing to practice medicine on an emergency room basis, just listen to the symptoms, make a judgment, and then throw the pills at the patient and then expect his adoration. I don't think medicine can be practiced only clinically.

What he wants the clinic to adopt is a single screening test to be administered to every patient. In his opinion, this procedure would resolve all his other frustrations—delays in the laboratory, inaccurate accounts from the patients, and time lost in his filing of the separate lab reports.

One of Dr. Roberts's complaints also involved delays caused by the testing procedure, but he laid the cause to the negligence of the personnel. Sometimes a test for which he has written orders in the chart gets passed over and when the patient returns, the doctor does not have "the key determination" at hand. As a result, both the doctor and the patient have wasted time. The other difficulty at Hilltop noted by Dr. Roberts concerned the one large room where the patients are interviewed and examined:

Dr: It's bound to be embarrassing for the patients out there in that big room because ordinarily when we're taking a history, we'll ask them if they've ever had syphilis or
gonorrhea and, you know, they must wonder who else, five or six other people around, may be listening to them. A doctor and a nurse on the other side of the room may be laughing and they'd be laughing at something totally irrelevant. But the patient wouldn't know that and the patient would think they were laughing at them.

Even with these complications, Dr. Roberts said he enjoyed working at the clinic, especially because the chief of staff at Hilltop has taught him well. The kinds of cases he described as characteristic at Hilltop were diabetics, hypertensives, and "alot of people that just come in to have somebody to talk to. . . . but that's fine. I'm not criticizing that."

**Piney Point.** Dr. Warren sees his primary task in working with "the indigent" as establishing "genuine rapport" with the patients and their families so that they will "divulge personal, intimate things" to him that can be crucial in determining proper treatment. He reported that important help in this task is provided by Ms. Fry, the administrative head at Hilltop who knows the background of many of the patients.

**Dr:** One day a patient had jaundice and I said do this and buy that and Ms. Fry says, "What are you practicing? This family hasn't the money to buy Coke." Maybe we tell a patient to sleep in separate, well-ventilated room. That's nonsense because he's in a house with two rooms only with six people. That is where a doctor like me—a foreigner, needs help from the clinic manager about patients' backgrounds.

In describing the setting, the doctors made available two primary features—the "cases" they see and the practical circumstances in which they work. These features, the practices involved in their production, and their significance in the doctor's accomplishment of his task are set forth below.

The fundamental practice involved in the doctors' discussion of
their cases consisted in typifying the patients along some dimension. These dimensions varied. Some of the doctors used medical criteria, as when Dr. Branch described his cases as entailing the chronic conditions of the elderly and acute episodic illnesses. Others, such as Dr. Glass, cited social-psychological criteria and depicted the typical case as female, poor, divorced, overweight, and depressed. Still others combined the dimensions. For instance, Dr. Roberts characterized the patients as diabetics, hypertensives, and "a lot of people that just come in to have somebody to talk to." Finally, some of the doctors used a "waste-basket" classification, as in Dr. Hart's statement that Woodhaven has "every type, age, race you can imagine. You get every possible illness." With regard to the point made throughout this chapter that social scenes are of an ambiguous nature and derive their sense through the imputation of meaning by the participants, it is to be noted that different doctors typified the "same" set of patients in different ways. For example, Dr. Henry typified the patients at Woodhaven as being people who are "poorly adjusted, people who are retarded and can't fit into life." Yet Dr. Dudley and Dr. Hart depicted the cases at Woodhaven as being "of all types."

For the purposes of the present study, the significance of these typifications lies in the part they play in the doctor's efforts to understand a patient, diagnose an illness, and decide warrant for his actions. That is, one of the ways a doctor finds the sense of a patient's remarks is to see what a "patient like that" could be talking about. If a doctor works with a typification indicating that his patients are retarded, poorly adjusted, and suffering from emotional
tension, then the patient's remarks are construed as pointing to these problems. Typifications are used in a similar way by the doctor in arriving at a diagnosis. If his patients are classified primarily as "depressed types," then the patient's symptoms--whatever they are--are seen as pointing to depression. Again, with regard to establishing warrant, a given course of treatment may be justified on the basis of its being appropriate for this type of situation (hypertension, loneliness, etc.). Further examples and a more detailed discussion of this point are found in Chapter Four, Chapter Five, and Chapter Six.

The second feature of the clinics made available by the doctors concerned the practical circumstances in which they work. They cited such items as the amount of time and space, the availability of supplies and services, the adequacy of the personnel, record-keeping procedures, and policies regarding drugs and tests. As was the case with typifications, the "same" order of events are described differently by different doctors. What is singled out as of predominant significance at a given clinic is replaced with another item by his colleague. For example, at Woodhaven, even though both doctors were using private practice as a standard of comparison for the clinic, Dr. Dudley stressed the many services available at the clinic, but Dr. Hart stressed the presence of white patients.

Several of the doctors invoked the notion of bureaucracy to account for their troubles. That is, attributes of that organizational form were used as a scheme of interpretation to make understandable certain aspects of the setting. Thus, Dr. Glass and Dr. Ferguson both cited the formal division of authority as responsible for tensions at
Greenland and Fairview. Dr. Hunter cited the required official forms and records as well as the written policies regarding treatment as a source of irritation.

For the purposes of the present study, the significance of the doctors' descriptions concerning the conditions in which they work lies in the fact that the doctors invoke these conditions as warrants in their efforts to present their activities as understandable. That is, the doctors frequently recommended the "reasonableness" of taking a given course of action by citing the situational constraints within which their task had to be accomplished. For example, the limited range of medications available at the clinic's pharmacy was invoked as the context from which to view the prescription of one drug (muscle relaxants) rather than another more preferred drug (tranquilizers) and thereby see this course of action as reasonable. Other examples and a more detailed discussion of this phenomenon are found in Chapter Six.

The settings for the research into the processes of communication between doctor and patient have been described, but the participants themselves have not. The patients range in age from sixteen to eighty, the doctors from young men just beginning their practice to those much older and semi-retired. Seven of the patients are men, fifteen are women. All the doctors are men. As for race, three doctors and four patients are white Americans. Six doctors and thirteen patients are black Americans. Five patients are Mexican-Americans. Two of the doctors are some other nationality.

While the race, dialect, age, appearance, sex, bearing and untold other personal characteristics undoubtedly affected interaction,
such features will not be detailed for each participant for three reasons. First, the participants were assured of anonymity as a condition of their involvement in the study. On the basis of what has already been presented and what will be presented, a knowledgeable insider may be able to identify some of the people. But this identification becomes increasingly assured when personal features are added. Second, it would only be my guess as to which of these personal features had some effect and what the nature of that effect was, since they were never referred to by the participants except in the form of typifications. The typifications and their use are discussed in the succeeding chapters. Third, these personal features are not variables from the standpoint of form. That is, the methods used by the participants to make sense of one another's talk and of their joint undertaking were found to be invariant. For example, drawing on typifications as a method of sense-making is invariant though the content of those typifications does vary.

In this chapter, I have been concerned with the features of the clinics and how they were made observable as features through my own accounts as an observer and through the accounts of the staff, the doctors, and the patients. I have stressed the point that the scene is essentially ambiguous until provided with a context that gives it specific sense. As the contexts varied, so did the sense. Thus the "same" scenes came to mean something different depending on whose expectancies were the basis of the description—the observer's, the staff's, the patients', or the doctors'. In the succeeding chapters, this attribution of context to decide meaning will be seen to be a basic feature of the process of communication.
CHAPTER FOUR

THE NATURE OF COMMON UNDERSTANDING

This chapter begins the analysis of the interviews between the doctors and patients. From the standpoint of an observer, these interviews followed a smooth and efficacious course. The doctor asked some questions; the patient answered them. The doctor identified the illness; the findings were written in the chart. The patient received prescriptions. The work was done. Similarly, from the standpoint of the participants, the interviews were regarded as successful. The patients said they had been skillfully listened to and competently cared for. The doctors felt they had adequately discerned the source of the patients' troubles and pursued a proper course of treatment. From the standpoint of the analyst, interest lies in 1) how that sense of understanding was accomplished; 2) how the findings were arrived at; and 3) how the work received its warrant as right and proper. This chapter will address the first of these considerations. The other two will be explored in subsequent chapters.

To determine how a sense of understanding was accomplished, I asked each doctor and patient to explain to me what he meant by his statements and what he took the other's statements to mean. As a result of these explanations, the process involved in making sense was made observable. To present the findings, I will first show that this process does not rest on or result in the establishment of matching sets of
content. Then I will show what it does entail, i.e. embedding the talk in a context. Finally, I will present the interpretive procedures that allow the context to be elaborated.

In my interviews with the doctors and patients individually, they each treated their joint conversation as having been a reasonable and sensible endeavor wherein a sufficient amount of information had been exchanged. Yet when I made a series of comparisons between the patient's account and the doctor's account concerning the import of given interchanges, I found numerous instances of divergence. That is, the doctors and patients told me different stories about many sections of their conference. These discrepancies appeared with regard to the meaning or intent attributed to an utterance.

My concern with these discrepancies does not lie in discerning the accuracy of one or the other report. Rather, my concern lies in searching out the ways in which the professed sense of shared agreement was sustained despite the fact that sequences of the exchange were construed differently with regard to actual substantive content. To observe how this sense of shared agreement is accomplished, I will proceed in accordance with the policy of ethnomethodological indifference and, as an analytical convention, suspend interest in the truth-value of the reports. This stance is held not only with regard to the pragmatic question of whose meaning—the doctor's or the patient's—was more nearly "correct" vis-à-vis the dictionary or the body of medical knowledge or even their own experience; but it holds also with regard to the question of the veracity of their statements to me. That is to say, they reported to me that they understood one another and set out to elaborate
for me what they had understood. Suppose they lied and "really" had no feelings that successful communication had occurred. Even so, they are doing the appearance of understanding for me. They are making understanding known to others. And it is the nature of that work that shall be investigated.

A few examples will be given at this point to illustrate the character of these divergent interpretations. The following exchange occurred between Dr. Dudley and Ms. Rankin:

Dr: I'm gonna give you a fluid tablet also but uh gonna, you're gonna have to take this liquid along with it uh so it'll balance out uh the potassium and what not that you're . . . (The patient spoke over his next words.)

Pt: Well now that fluid pill that I was taking there made me deathly sick.

Dr: Oh it did? OK. Let me check and see which one it was. (The doctor looks in the chart.)

Pt: Oh, it made me sick!

Dr: Well, we don't want to add anything to,--Lasev. Well now I'm gonna give you a little yellow one and if that makes you sick stop 'em right away, hear? It's not the same as, as the other.

In the later interview, each was asked to elaborate on this exchange.

Ms. Rankin gave the following account:

I: You said the fluid pill made you sick. What kind of sick?

Pt: Ooh, just plain sick sick. You know how if you're preg-nant--it's horribler than that.

I: You mean throw up?

Pt: Yes, the heaves.

The doctor's elaboration differed from the patient's:

I: The patient said the fluid pill made her sick. What kind of sick?
Dr: Unless you give potassium chloride with fluid pills, she can get, patients can get awful sick—abdominal cramps and leg cramps and all of this, because fluid pills pull potassium out of your body. That's why I told her I was giving her that liquid with the pills and if she takes that she probably won't experience that sickness.

The pivotal word here is "sick." The patient said her "sickness" consisted of "the heaves," comparing it to the nausea common in pregnancy. The doctor has taken her word as pointing to abdominal and leg cramps, a set of pains she has not reported to him and did not report to me. The "sick" he hears her talking about is one he expects to find, given the side-effects he associated with the medication she has been taking. In fact, he had considered the possibility of an imbalance of potassium, and already taken steps to correct it, before she even mentioned her sickness. For his part, the symptoms are now accounted for and he acts on the basis of his conclusions to prescribe a different kind of fluid pill. For her part, the patient goes on in subsequent portions of the interaction to discuss with the doctor the time sequence appropriate for taking her various medicines, treating his new prescription as a direct response to the complaint she had offered.

The second example to be given here is from the conversation between Dr. Scott and Mr. Martinez.

Dr: Now hypertension (unintelligible). You have no not any many more symptoms of headache?

Pt: No sir.

Dr: You feel nervous, tense?

Pt: No.

Dr: Any visual, any differences in eye vision?
Pt: Nothing.

In my interview with Mr. Martinez, the following exchange occurred:

I: He asked you if you had headaches or were nervous or tense, or had visual problems. Had you ever had those before?

Pt: No.

I: Had he ever asked you about that before?

Pt: Uh, well, he did ask me but he asked me if what was anything that I get visual problems, something like that, and he, I think he asked me because of the medicine he gave me maybe, but uh, if they bothering me or something. I think that's why he asked me.

I: About the headache and the nervousness too?

Pt: Mmm hmm.

I: That maybe the medicine was bothering you?

Pt: Yeah, 'cause he changed it, see, and he wants to know if the medicine would have some other kind of reaction on me.

Later in our conversation, Mr. Martinez declared, "Every question that he asked me today is concerning the medica, the medicines he gave me with the medication has been changed."

The doctor's version of the exchange is as follows:

I: What was behind your question, did he have headache, nervous tension, or visual problems?

Dr: Uh, the hypertension, because they originally were, were stated.

I: And when he said no, that he didn't have them ...

Dr: I didn't press it further on because uh it corroborated the impression I got by leafing through the chart that his hypertension is sort of controlled.

Mr. Martinez has taken the question as a query about possible side-effects of a new drug and regards his answers as a response to this
question. Dr. Scott states that his intention is to check on the con-
tinued presence of symptoms related to hypertension and has regarded
Mr. Martinez's answer as a confirmation of his belief that the condition
is under control.

A third example will be taken from the interview between Dr.
Compton and Ms. Flood.

Dr: How much of the Benedryl are you having to take?

Pt: Mmmm, lessee, I taken something Friday, Saturday. I
didn't take any yesterday. I haven't taken any today,
'cause I didn't felt, you know, nauseated, today or
yesterday.

Miss Flood's elaboration of this exchange is as follows:

I: How about when he asked you how much Benedryl you'd
taken. What did you think he was asking you that for?

Pt: Well, I guess to see had I taken any of the medication,
'cause alot of people when they give it, give 'em medi-
cation, and sometime I do that when they give me medica-
tion I won't take it, take it home and throw it in the
drawer and that'd be the last time you'd see it until
I get ready to clean up and then I throw it away.

When I asked Dr. Compton why he had inquired as to the amount of Bene-
dryl the patient had taken, he answered that he was trying to find out
how nauseated she had been. He continued:

Dr: Some people say, are saying they're, will say that
they're doing all right. But actually they're, they're
taking, they're having to take the medicine every uh
just as often as they can in order to suppress their
symptoms. And you're, you're uh uh, what they're try-
ing to do is saying yeah that your treatment's working.
(Laugh.) And you might, might assume when they say
that that they're well and they, they're not well.
They're just, they're just uh, that your treatment's
working. She said that she hadn't taken the Benedryl
in a couple of days so I figured she's all right.

Here the patient perceives the doctor as checking to be sure she has
followed his prescribed treatment, a check she regards as appropriate since some people, including herself at times, fail to take their medicine. The doctor regards the check as necessary because some people take their medicine so faithfully that it becomes difficult to judge whether their illness is cured or their symptoms merely suppressed.

The discrepancies in these examples, as in the others found in the data, present a challenge to the generally held belief that difficulties in communication between doctor and patient reside in the doctor's use of medical terms unfamiliar to the patient. According to that view, the recommended remedy is for the doctor either to explain his technical language or to avoid it altogether. Professional investigators (Pratt, et al., 1957; Samora, et al., 1961; Plaja, et al., 1968; Korsch and Negrete, 1972), as well as lay members, subscribe to this view. Indeed, several of the doctors and patients involved in the present study made explicit reference to this stance. For example, Dr. Branch, when asked if he thought his patient had understood him, replied, "Partially."

I: Was there any particular place you thought it was only partial?

Dr: No, I just have that feeling that uh perhaps uh she didn't understand uh maybe some of uh my terminology and things like that. But then I catch myself, uh try to, and I'll repeat it maybe in a different way. Sometimes I have a tendency to do that. But I thought that uh you know, I've talked to her before and she can grasp things very well.

Ms. Franklin is the patient speaking in the following exchange:

I: Was there anything Dr. Glass said that you didn't understand?

Pt: Unh unh. He talks to patients on their level. And he doesn't use medical terms all the time and when he does use one, he doesn't just say it and keep on going, he stops and tells you what it means.
The assumption underlying the view typified by these remarks as well as by those made in professional investigations is that the primary factor permitting the existence of common understanding is shared vocabulary. This factor is held to be primary because of an even more basic assumption, i.e. that common understanding is essentially a matter of shared agreement on relevant topics. Following these two assumptions, so the argument goes, once "plain language" familiar to everyone has been substituted for esoteric medical terms, substantial overlap should obtain in what the participants take the conversation to mean. It is exactly this "plain language," however, that is involved in the discrepancies found in the data regarding the meaning attributed to various statements. Talking in non-technical words has not assured a statement's being taken by speaker and auditor as referring to the same state of affairs. In fact, the use of ordinary language brings along its own set of troubles in this regard. Everyday speech consists largely of indexical statements, i.e., statements that rely for their sense on the "pragmatic context of their production" (B̄er-Hillel, 1954:359). Since each participant supplies the context privately and on his own, there is only the merest chance of substantial overlap. And yet, my argument will be that this very process of supplying a context underlies common understanding.

The notion that understanding is the result of amounts of shared agreement on substantive matters is in error. Shared agreement cannot be documented. In fact, quite the opposite is the case. Examination of the data revealed many instances of no shared agreement. In the examples already given, we read divergent interpretations of the word
"sick," divergent interpretations of the import of questions about a series of symptoms, and divergent interpretations about the significance of the amount of medicine that had been taken. Similar instances occurred over and over in the interviews. Nevertheless, doctors and patients had no difficulty getting through their exchanges with one another and apparently convinced each other, themselves, and me that understanding was present.

If understanding does not reside in overlapping constructions of topical issues, where does it lie? My proposal is that understanding rests not on shared agreement but rather on a sense of shared agreement, a sense that will obtain so long as the participants can attribute some meaning to one another's statements. Commonality of what is attributed is not central to the preservation of the integrity of the conversation. What must be shared is the assumption that the discourse is indeed sensible and a commitment to making it make sense. As was pointed out above, this sense-making is accomplished by supplying a context to what is said. As Dr. Hunter put it, "You have to try to see from what they say, what could have happened to them to cause them to say what they say." So the two points being made here are that common understanding arises from the assumption that the conversation is intelligible and that this intelligibility is established by embedding the talk in a context.

The context is constructed from bits and pieces of the participants' own experiences, from typifications, idealizations, maxims, expectations, scientific theories, assumptions about the past course and future prospects of the ongoing conversation, and so on.
Illustrations of this endless array of available items are seen in the excerpts already given. Ms. Rankin invoked the general knowledge concerning the nausea associated with pregnancy as the context out of which she spoke the word "sick." Her doctor drew on his professional experience with the use of fluid pills, the lack of potassium, and resultant cramping, in describing the context out of which he spoke the word "sick." Mr. Martinez embedded the doctor's questions about a series of symptoms in his assessment that the doctor's primary interest throughout the interview resided in discovering the side-effects of the new medication. His doctor's stated vantage point was the medical history of his patient, specifically, his previous complaints about headache, nervousness, tension, and visual problems. In constructing the contexts surrounding their talk, Dr. Compton and Ms. Flood both used typifications about patients' habits regarding taking medication, though the meaning of these typifications took them in opposite directions. Although these contexts differ in the items that comprise them, i.e. whether common knowledge was invoked, or professional experience, assignment of motives, medical history, or typifications, the effort to make sense and to do it in this way was ever-present.

Let us look at a further example to see the kind of filling-in that occurs to find the meaning of an utterance. In the conference between Dr. Henry and Ms. Vaughn, the subject of her obesity was raised:

Dr: Now when it comes to your obesity, I think that uh you're a bit obese and there isn't too much that you could do about this thing. What are, what are you doing about your overweight?

Pt: Well, I just gotta cut down, not eat alot, but I haven't done really anything about it since I was (unintelligible) at the Weight Watchers and I haven't . . .
Dr: (interrupting) Well, you must, you must come back.

Pt: Yes sir.

Dr: Now the point of it is, uh you've got this problem with weight. This is a problem of uh, it's a psychological thing, it's a, it's something like a, you, you, you're nervous because of home sitcomations, see? So (unintelligible) yourself, understand?

Pt: Yes sir.

Dr: And uh, so therefore when people get, another thing about it, when people get nervous and all that kind of thing, they overeat. And that's one of the main reasons for people uh becoming very obese, you see? They, you have problems with the children you said, see? That makes you nervous, that makes you overeat, and that makes you get overweight.

Pt: Yes sir.

Dr: See? So, that's it. You just have to work on, watch yourself so far as that's concerned. You're going to Weight Watchers and there's one other thing as I said that I know you'll have to do, you'll have to work out your own problems so far as the home sitcomation is, relation with your family.

Pt: Yes sir.

When I asked Dr. Henry about his statement that nervousness leads to overeating, he replied:

Dr: Well, the only thing I thought about when I saw her, I read a little article in the paper some years ago, and I think it said, "Oh, the curse of obesity!" It's a curse that some people have. It's a glandular thing and I wonder sometimes if, what, what, what, what can you do to overcome this types of things. Well now, not only that, but uh, being a glandular thing, alot of these people, it's not a glandular thing. They're so disturbed in many planes of their lives such as family problems, financial problems, and everything and they eat (unintelligible) to satisfy their emotions. Now what are you gonna do in a case like that? See?

In my interview with Ms. Vaughn, the following exchange occurred:

I: What did you think about his explanation when he said that he thought that the nervousness led to overeating
and overeating to overweight and overweight to some of your other . . .

Pt: Well, the only thing I could uh say on that, it's true, because this is why I'm so large, because when I had my first child, I weighed about a hundred and eighty, and from my first child to my fourth child I weighed three hundred and fifteen when my last one was born. And that is from nervousness, because my first child hollered six months that he's born for all the time, and I wouldn't really realize I (unintelligible) had played up, and I'd just sit there and look out the window because he was the most holleringest baby I ever found in my life, my first child. He hollered so until, when he got older, he had to have surgery to fix his navel 'cause it was so bad 'cause he would just continue hollering and I don't know why. But that was my first child and then I was new with him and he drove me up the walls. And I didn't even know I'd gained weight and I put on a dress one day and went to town and it was good it was winter time because when I come back the whole dress was all ripped out on both sides and I opened my coat up and I didn't have on nothin' but just front and back 'cause I had gained that much weight from eatin', just eatin' because I was just so nervous from him hollering', hollering', hollering', hollering', hollering', and I had done everything I could. . . . And uh that was my beginnin' of eatin' too much, feelin' nervous more and more.

Ms. Vaughn has filled in the doctor's explanation about the connection between nervousness and obesity with all these details from her own past experience. They did not discuss the crying of her first child or his surgery or her staring out the window or her trip to town when she ripped her dress. She had told him earlier in their conference only that "the chi'ren are makin' me too nervous." He filled in her remark by drawing on a typification of the kinds of problems "these people" routinely face and taking her statement as referring to these problems. He then applied his theory connecting emotional disturbance to overeating. She, in turn, filled in his stated theory with various details from her
own past experience—details Dr. Henry has no knowledge of and did not mention. Her crying baby, her efforts to quiet him, her trip to town, her torn dress, are all seen by her as the items to which his theory is relevant, even though these items were not mentioned by the doctor. In other words, both Ms. Vaughn and Dr. Henry understood one another not only on the basis of what was said but also on the basis of what was left unsaid. ¹ It is this effort to fill-in that Zimmerman and Weider point to in the following declaration:

... members continuously rely on, and if pressed insist upon, the capacities of others to find a presumptively shared sense in what they are saying (1970:294).

This presumption that a shared sense is found gives rise to another point about common understanding. That is, each participant to a conversation treats the context he has constructed as the context for the talk. Therefore, he regards the other's statements as direct responses to his own. This alignment is illustrated in the elaborations by Dr. Henry and Ms. Vaughn. The doctor took her remark about the children's making her nervous as related to his theory of obesity. She, in turn, took his stated theory as referring to her remark and uses that theory to connect her nervousness with her obesity. (The alignment is also referred to in the earlier examples.)

Note that in this example as in the ones presented earlier, neither patient nor doctor attends to the statements contained in the discourse. They do not even attend to the meanings—referential or otherwise—of the words or statements. Instead, they look for what lies behind the discourse, saying, "What does he really mean?" The utterance itself is discounted except as a token of something else. ²
The work of looking behind utterances and finding their meaning by embedding them in a context rests on a set of interpretive procedures. These have been formulated by Cicourel (1970a; 1970b) and will be outlined here. At the close of the chapter, we will return to them for a fuller discussion.

1. **Normal Forms.** When members engage in interaction, they assume that each other will emit utterances that are intelligible, recognizable, and embedded within a body of common knowledge. Also involved is the assumption that each is understanding what the other is saying.

2. **Et Cetera Principle.** Under the et cetera assumption, members take it for granted that the hearer will fill in the unstated but intended meanings of the speaker's expressions. The et cetera principle also includes the notion of the retrospective-prospective sense of occurrence. That is, the hearer assumes the speaker will say something later to clarify a previous utterance.

3. **Reciprocity of Perspectives.** This assumption has two facets. The assumption of the interchangeability of standpoints allows a member to treat himself and the other as occupying the same social setting such that if they exchanged positions, each would see what the other sees. The second facet involves an assumption of the congruency of relevance. Members assume that although they have different biographical circumstances, their experiences are sufficiently congruent so as to ignore until further notice any differences that might occur because of personal experiences and perception. Should a discrepancy be noted, however, this notion of differences in biographical circumstances is used
to explain divergent interpretations of the same event, thereby preserving the facticity of that event.

These interpretive procedures are basic to all interaction and are continuously operative. As will be shown at the close of the chapter, these assumptions can provide an ongoing sensible character to a conversation even in the face of perceived obstacles. That is, there were times when a doctor saw his patient's statements as standing in direct conflict with the true state of affairs. Similarly, there were times when a patient saw his doctor's statements as standing in direct conflict with the true state of affairs. In such cases, the participants found a way to resolve the conflict and thereby maintain the sensible character of the conversation. Some excerpts will be given that illustrate the occasions where credulity was strained. First, two examples involving such occasions for the patients will be considered.

During their interview, Dr. Dudley and Ms. Perkins discussed the progress of her attempts to lose weight:

Dr: Well, what about your weight?
Pt: It's still up. I'm trying to lose.
Dr: It's interesting that you're weighing the same thing today that you weighed when you first came in—one ninety-four.
Pt: It went up from that.
Dr: It went up from that and then came back down. Have you been dieting or has this just been uh, yeah, you went [looking at her chart], oh, this must be wrong 'cause it's one fifty-nine.
Pt: That was wrong.
Dr: That was wrong. Wish it could get down to that. Yeah, you've been up over two hundred a couple of times.
Pt: I was, yes.

Dr: That's good, well, we're gonna try to keep you on a downward grade on that weight because I think you'll feel better.

Later, I asked Ms. Perkins to tell me why the doctor was concerned about her weight. She responded:

Pt: Well, I don't know. It doesn't seem, you know, unless'n I get over two hundred, I don't feel, you know, it doesn't bother me too much. But if I get too heavy, well then I'll feel it. I'll have a pressure. I can feel it in my chest. I, I'll get short of breath. And, and so, but ordinary, you know, when I stay down less than two hundred, it doesn't bother me. I mean I don't notice too much about it, but they may could see something that I didn't know.

Ms. Perkins had heard the doctor from within the context of her own experience. When her weight is over 200, she has problems. Since her weight is under 200 and she has no bothersome symptoms, she cannot find a reason to account for the doctor's concern. In order to resolve this conflict that she sees between the doctor's statements of concern and her own belief regarding the time when such concern is really called for, Ms. Perkins invokes the notion of expertise. It is not that the doctor is talking nonsense. Rather, he has access to specialized knowledge and therefore has his own good reasons for advising what he does. Should this knowledge later be made available to her, then her own assessment may be revised.

A second example of a conflict noted by the patient is taken from the reported experience of Ms. Kinkaid with Dr. Scott. During their conference, Dr. Scott and Ms. Kinkaid had the following exchange:

Dr: I am checking here [in her chart] all your electrocardiogram. ... Your heart function's normal except I see here a little tiny change which is due to that
emphysema you have. You know, I, I would like to tell you uh uh the smoking ought to go because emphysema is not a lung disease. It is a lung disease.

Pt: Mmm hmm.

Dr: But eventually it's a heart disease. It, uh, you know, this is, uh the heart, the pump, has to push the blood through the lung and so it's, and I see that change already on your electrocardiogram. You know, it's the right side of your heart, one day is gonna give out. And uh from the medical experience, this is how people with emphysema end.

Pt: Mmm hmm.

Dr: Because it strains the heart without letting the patient know.

Later in their conference, Dr. Scott added:

Dr: You know, I told you that emphysema is not a lung disease. It's a heart disease, because, I mean, whatever you think of it, take my word for granted.

When I talked with Ms. Kinkaid, I asked her about these statements by the doctor:

I: He kept saying, you know, that emphysema is a heart disease not a lung disease. What did he mean by that?

Pt: Well now, I don't know. I thought uh, I don't know what he means. There's some of 'em that has emphysema, it's, the way I understand it now, I'm sure everybody's different, that don't have this trouble with their bronkal tubes. They just are short of breath all the time. And can't breathe.

Later in the interview I asked again:

I: Remember at one point, after he had said again about emphysema being a heart disease, he said, "Now you take my word for it, you take my word for granted." What did you think when he said that?

Pt: Well I didn't know just what he really meant. Didn't really know.

I: What did you think about his asking you to take his word for it?
Pt: Well I believe him (laughing), sure. I guess he knows more about what he's talking about than I do. More'n I know.

Ms. Kinkaid has had emphysema for several years and until recently was being treated at the pulmonary unit of a local hospital. It is her understanding that the disease affects the lungs and/or bronchial tubes. Dr. Scott's statement conflicts with previous explanations given to her. The conversation has not become nonsensical to her because, though she does not know what he is talking about, she assumes he does.

In these examples as in others that could be presented, the sensible character of the conversation has been preserved by faith in that selfsame sensible character. That is, while the patient cannot assign a specific meaning to the doctor's utterance, believing that at least he knows its meaning is enough to maintain the status of the interview as a reasonable enterprise. The other significant feature of these cases is that the device chosen by the patients to resolve the conflict does minimal violence to the integrity of their own perceptions. Their own assessment is allowed to stand alongside the possibility that a revision might be required in light of the doctor's professional knowledge.

Let us turn now to some occasions on which the doctors were faced with similar conflicts. Mr. Gulifton complained of a large swollen area on his elbow and showed it to Dr. Henry.

Dr: When did you first notice this on here?
Pt: Oh, it commence Friday, first time I noticed it.
Dr: Just came up here all of a sudden Friday?
Pt: Yes, yes, all of a sudden.
Dr: Well had you been straining yourself or anything like that, lifting something?

Pt: Oh, yeah, I been (unintelligible).

Dr: You had been lifting something.

Pt: Yeah, but this happened all of a sudden.

In the subsequent interview with Dr. Henry, the following exchange took place:

I: Was there anything that he was telling you that you had difficulty understanding what he meant?

Dr: Mmmmm, no, nothing more than what he meant when he told me about that arm, and this thing came up here all of a sudden, that, that, that I couldn't understand that, couldn't understand that because I've never seen one come suddenly except that you get hit, you see, see. He hadn't been, he hadn't been looking back there to see, you see. It just gradually came on, you understand? Then one day he laid his arm down on his chair and finally felt it.

Here the patient's report of the sudden onset of his symptom conflicts with Dr. Henry's medical opinion of and experience with such cases.

In order to resolve the discord, the doctor suggests that the symptom actually did appear gradually but went unnoticed for a time by the patient. It was the noticing that was sudden, not the onset.

The second example of a conflict noted by the doctor arises from the conference between Dr. Hunter and Ms. McMillan:

Dr: Ok. Well, let's see about your feet swelling up down here. Feet swell up on you any time during the day?

Pt: Naw, I don't get that.

Dr: Do you get shortness of breath near the end of the day, get tired easy?

Pt: No, naw, none of it, I don't, I aaah, I don't get none of that.
In my interview with Dr. Hunter, I inquired about that exchange with Ms. McMillan:

I: What about when you asked her if her feet were swelling or if she had shortness of breath, or was tired, that series of questions?

Dr: That's the picture that go along with the over-all cardiac-renal problem with age, hypertension, renal damage, et cetera, et cetera.

I: And when she said no, that those problems weren't bothering her right now, what did you take that to mean?

Dr: That, as far as she knows, she hasn't been bothered with them enough to stop her from her daily intek, intek, a, activities. But I imagine if you would check her possibly at the end of the day, you might could pick up a little bit that she just living with because she live hard so long one more little hardness is not gonna bother her too much.

In Dr. Hunter's professional opinion, certain symptoms regularly accompany the condition Ms. McMillan has. Her report that she does not have those symptoms must be reconciled with his expectation. He decides that the symptoms are present but seem minimal to the patient in comparison with her other problems.

These examples are two of the many instances in which the doctors saw a conflict between their own body of knowledge regarding the course of an illness and the patients' report of that illness. In every case, the doctor resolved the conflict in such a way as to keep intact both his medical theories and the patients' experience. That is, in the case of the conflict between Mr. Gulfton's report that his elbow had swollen suddenly and Dr. Henry's medical opinion that such swellings occur gradually, Dr. Henry's resolution held that the swelling came on gradually but Mr. Gulfton noticed it suddenly. In this way, his own
stock of knowledge was not brought into question (i.e. the swelling was not sudden), but neither was the patient's experience (i.e. the onset did appear to be sudden).

Similarly with the case of the conflict between Dr. Hunter's knowledge of the symptoms associated with cardiac-renal problems and Ms. McMillan's report that she did not have those symptoms. Dr. Hunter's resolution stating that the symptoms are there but have gone unnoticed allows his own medical opinion and her reported experience to stand. The point made by these two examples, and by others that could be given, is that the doctors fashioned a scenario that could account for the patient's report as a legitimate one from his own point of view rather than as a piece of nonsense. At the same time, the scenario allowed the doctors' own store of medical knowledge and experience to take precedence in the description of the "actual" state of affairs.

To draw into sharper focus the interpretive work described throughout this chapter, let us return to a discussion of the procedures formulated by Cicourel. In his view, these interpretive procedures do not constitute a list of rules that can be enacted with a greater or lesser degree of correctness. Rather, they are a set of assumptions which, operating together, allow the members of society to assign meaning to an endless variety of displays and to preserve the latter as an environment of sensible events. Referring to the members' use of these procedures is to speak metaphorically, for their "use" consists of their being assumed by members, assumed of themselves and of others. Moreover, presenting these interpretive procedures as separately definable items is done purely for expository purposes. Empirically, they fade together
and interact with each other to form an unbroken interpretive process.

Again, the basic assumptions which constitute the interpretive process are as follows:

1. **Normal Forms.** When members engage in interaction, they assume that each other will emit utterances that are intelligible, recognizable, and embedded within a body of common knowledge. Also involved is the assumption that each is understanding what the other is saying. This assumption of normal forms prevents talk from dissolving into an infinite regress of self-doubts by instructing members to appear to understand and to expect that the talk refers to a common repertoire of appearances in the society.

   It is the operation of this assumption that can account for the findings that the doctors and patients maintained a sense of shared agreement in spite of divergent interpretations, that divergent interpretations frequently remained hidden, and that when they did become apparent, efforts were made by both parties to normalize such discrepancies. These efforts were based on the other two assumptions: the et cetera principle and the reciprocity of perspectives.

2. **Et Cetera Principle.** Under the et cetera assumption, members take it for granted that the hearer will fill in the unstated but intended meanings of the speaker's expressions. As was pointed out earlier, much of our talk consists of indexical expressions whose specific sense must be decided by going beyond their surface form (the appearance and sound of the terms) and kernel meanings (definitions given in a dictionary), and embedding them within a context. In the examples given in this chapter, we saw the doctors and patients
constructing the context on the basis of such particulars as professional expertise, typifications, and what is taken to be common knowledge. Especially in the excerpt from Ms. Vaughn, we saw the work of taking the doctor's essentially vague and certainly truncated statement regarding a theory of obesity and making it specifically and personally relevant by supplying a series of details from her own past history.

The et cetera principle also includes the notion of the retrospective-prospective sense of occurrence. That is, the hearer assumes the speaker will say something later to clarify a previous utterance. This assumption underlies, for example, Ms. Perkins's willingness to let pass for the present Dr. Dudley's expressions of concern over her weight even though she does not know the reasons prompting that concern. For "they may could see something that I didn't know." This notion leaves the possibility open for the legitimacy of some future clarifying statement.

3. Reciprocity of Perspectives. This assumption has two facets. The assumption of the interchangeability of standpoints allows a member to treat himself and the other as occupying the same social setting such that if they exchanged positions, each would see what the other sees. For example, Dr. Hunter's statement that "you have to try to see from what they say what could have happened to them to cause them to say what they say" rests on this assumption. In other words, he takes it that if he had stood in their place or had their experiences, he would have given the same report they did. So by imagining himself in their situation, he can re-construct the conditions that gave rise to their statements.
The second facet of the reciprocity of perspectives involves an assumption of the congruency of relevance. Members assume that although they have different biographical circumstances, their experiences are sufficiently congruent so as to ignore until further notice any differences that might occur because of personal experiences and perception. Should a discrepancy be noted, however, this notion of differences in biographical circumstances is used to explain divergent interpretations of the same event, thereby preserving the facticity of that event. Dr. Hunter's remark about Ms. McMillan invokes this assumption. Although she reported the absence of swelling in her feet and shortness of breath, he believes she does have such symptoms. He says it is simply the case that "as far as she knows" she has not had the symptoms. That is, she does have the symptoms but has not noticed them because of her own personal circumstances: "... she live hard so long one more little hardness is not gonna bother her too much."

The topic addressed in this chapter regards the nature of the process involved in maintaining a sense of common understanding. Four central points have been made concerning this process. First, there is an underlying assumption that the conversation is intelligible. Second, the intelligibility of the conversation is made out by assigning meanings on the basis of an elaborated context. Third, each participant to the conversation regards his constructed context as the context and therefore treats the other's talk and action as a direct response to his own talk and action. And fourth, if a discrepancy should become apparent, an effort is made to resolve it in such a way as to preserve the integrity of the conversation and of the personal knowledge and
experience of each participant.

Re-casting these points into the terms given by Cicourel, we saw that a sense of common understanding was accomplished by the doctors and patients through the use of interpretive procedures. The assumption of normal forms—i.e. that the discourse was indeed sensible—prompted the efforts to make it make sense by supplying a context to the talk as "instructed" by the et cetera principle. When discrepancies in interpretation became apparent, they were resolved by invoking the reciprocity of perspectives. In this way, the doctors and patients retained the integrity of their own separate perceptions without casting into doubt the notion that they were dealing with one and the same reality.
CHAPTER FIVE

FORMULATION OF A DIAGNOSIS

In the last chapter, common understanding was shown to rest on the ability to embed a statement in a context and thereby fill out its unstated meaning. Similar work is required in order to make sense of symptoms. This chapter will examine that work in three stages, each representing a more detailed examination than the last. As a beginning, I shall present an illustrative conference between a doctor and patient, and point out the process of embedding a symptom in a context. This process will be identified as the documentary method of interpretation and its features will be discussed. Second, I shall present another case, again showing the features of the documentary method, but also specifying the practices involved in its use. Third, I shall present the ways whereby the doctors established a connection between the general guidelines they invoked to construct a context and the specifics of a given case.

To begin an exploration of the interpretive process involved in arriving at a diagnosis, let us examine the interview between Dr. Ferguson and Ms. Brown:

Dr: Ok, what's the main thing botherin' you today?
Pt: I didn't have anything, only these terrible headaches. Uh, my head been hurting.
Dr: 'S been hurting?
Pt: Mmm hmm.
Dr: How long has it been hurting?

Pt: Uh, since yesterday.

Dr: Ok. What part of your head hurts?

Pt: Right up in here and I have some pains over in here. (The patient is indicating right front and temple.)

Dr: Mmm K. Does it stay there or does it run down the back?

Pt: It runs down the back. My teeth been botherin' me too, since I figured that's probably what it was.

Dr: You got some bad teeth?

Pt: Mmm hmm.

At this point, the doctor examined her by pressing upon areas of her face and her gums, and by looking inside her eyes and ears.

Dr: ... Is your headache worse at nighttime or during the day?

Pt: During the daytime.

Dr: Is it worse when you're runnin' around and things are happenin' around you and you get nervous and upset?

Pt: Mmm hmm.

Dr: I don't find anything else that looks bad, you know, besides your teeth, but you don't have an abscess in your teeth, just some cavities and a gum disease. Do you get any exercise?

Pt: I plays ball sometime in the evenin'.

Dr: That's good. If you keep your body in better shape, it won't react quite so much to gettin' tight and upset, and nervous, you know. . . .

With his questions, Dr. Ferguson was seeking to surround the symptom of "terrible headaches" with various ethnographic details. To this end he has inquired about the duration of the pain, the exact area of the pain, the extent of the pain, the time of its greatest severity, and
activities associated with it. Now, what did the doctor do with the patient's answers such that a specific diagnosis was made possible for him? Consider the doctor's account of his findings:

Dr: I, I had seen her twice before, and uh both times she had had a non-specific symptom, a little bit of dizziness one time, something else the other time, and I think twice she had not kept her appointment to come back and each of the three times she's been here she's had a slightly different complaint, nothing severe, so it was just that type of situation. So she came in this time with headaches, so I checked through the common things that cause headaches in our population, the teeth, the sinuses, the joints, the ears, look in the eye-grounds for any evidence of the tumor that might be increasing pressure, and then talked with her just a minute about what tended to bring about the headaches, and in the vast majority of people it is associated with uh anxiety and tension. . . . And I uh gave her some mild medication for her, for her headache. And her, her affect was not appropriate to the severity of the headache, really. She didn't look like she had, had had much headache or pain. Some people you can tell they look like they've had a headache. She didn't look like she had had much, and she had kind of affected me the same way before when she had come in. She's had a little dizziness, but it did not impress me that it was really anything significant and ordinarily a lot of people wouldn't have gone to the doctor for that, you know. And uh, she did have some gum disease and I don't think that's causing her pain 'cause she didn't have any tenderness anywhere along her teeth. So I think basically she just uh was probably sitting at home and didn't have alot to do. She gets headaches, and this is the one place she can go free of charge and somebody can give her attention and that's what alot of our patients are, you know, and they, its just that type of situation.

Dr. Ferguson has diagnosed Ms. Brown as suffering from tension headache by embedding her symptom in a context constructed on the basis of three sources. First, he drew upon his background knowledge of his patient. He noted that she had come to him several times with "a slightly different complaint, nothing severe," and mentioned his experience with her failing to keep two appointments. He saw this information as alerting
him to the possibility that again his patient might be coming with a vague and mild complaint.

Second, Dr. Ferguson cited his general characterizations of his patients. He typified the way people look when they have a painful headache. He generalized that "alot of people wouldn't have gone to the doctor" with the problem Ms. Brown has presented. He characterized many of his patients as seeking attention "free of charge." These typifications were used by the doctor in assessing how painful her headaches were, how serious they were, and what might have been the patient's motivations for visiting him.

Third, the doctor made use of his stock of knowledge about disease available to him as a trained physician. From this vantage point, he was able to list what he regarded as "common things that cause headaches in our population." Further, he could categorize headache in the vast majority of people as a concomitant of "anxiety and tension."

Using these sources as guidelines that instructed him on how to interpret a given situation, the doctor has composed a story that accounts for his patient's symptom. She suffered from boredom and from a tension headache. The clinic was an opportune place to go to relieve both.

The process employed by Dr. Ferguson to assign meaning to a presented symptom is similar to the process described in the last chapter. There it was shown that common understanding relies on the participants' capacity to assign meaning to a statement by embedding it in a context. Establishing the meaning of a symptom relies on the same work. This procedure of constructing a context entails the documentary
method of interpretation. As described in Chapter One in the definition by Garfinkel, the method consists of treating an observed appearance or series of appearances as standing on behalf of an underlying pattern. In the case just discussed, the appearance was the patient's reported headaches. The doctor found its significance by seeing it in light of an underlying pattern of boredom, anxiety, tension, and need for attention. Assembling the pattern—deciding what his observations could be evidence of—was accomplished via his background knowledge of the patient, his typifications, and his medical expertise.

Three fundamental features of the documentary method are prominent in the case presented. First, the relationship between the observed appearance and the underlying pattern is one of mutual elaboration. That is, as we have seen, the pattern comes to be known through appearances taken as evidences of it. But at the same time, what the appearances are seen to be is derived from that self-same pattern. In the case given above, Ms. Brown's headaches are understood both as pointing to and arising from a basic state of boredom and anxiety. This underlying pattern serves to inform him about the symptom in that the headaches come to be seen as produced by tension, boredom, and loneliness (as opposed to, for example, tumors or diseased gums). The headaches have served as a clue to this pattern in that such a minor problem would not have been brought to the doctor's attention were not the patient tense, bored, and lonely.

Because of this mutual elaboration between appearance and pattern a change in one will lead to a change in the other. This second feature of the documentary method is illustrated in the following
statement by the doctor:

Dr: In effect what you're doing is you're saying I'm gonna check the things that would require medical care and attention in the limited time I have and if I see no evidence of anything then I'll pile it over into the trashcan where everything else goes and call it tension headache. If she continues to come back over and over with headaches, then we begin to work more, you see.

Should the headache persist, then what it is taken to signify will be altered and additional examination will be done. Furthermore, the sense of what it "really" was at this first presentation will be altered. For example, were she later found to have a tumor, this present headache would then be seen as having been its sign all along.

Third, a kind of projection or objectification occurs such that the circumstance is seen by the doctor as independent of him, as standing alone and apart from him. Twice in his account he referred to it as "just that type of situation" with no real awareness of his part in making it "that type of situation" by his own evaluation of it. The defining attributes of the case are seen by him as inhering in the case itself, "out there" and available to any competent observer.

Now that the basic outline of the use of the documentary method has been presented, I shall offer another example and detail more closely the practices involved. The following excerpts are taken from the consultation between Dr. Glass and Ms. Franklin:

Dr: Ok. So how're you getting along?


Dr: Almost?

Pt: Mmm. I still have that, I still have alot of that uh alot of that feeling uh like cramps. It's really bothering me.
Dr: In your stomach?

Pt: Mm hmm. You know that, um, you, um I almost passed out last night, I was so scared.

Dr: What were you doing when you almost passed out?

Pt: Nothing. Oh, I went up to my father's house and we was fixin supper and everything and then we was, we was all going to help him move this uh this kind of a, a desk thing. And its not really heavy but we was going to have to lift it up, and I went over there and stood by it and I just got, I don't know, I just got, I just felt like I was, I got real, real hot, and I just, I just went down.

Dr: Did you fall on the floor?

Pt: Uh huh. Hurt myself too.

Dr: Were you unconscious?

Pt: I just passed out.

Dr: Have you ever passed out before?

Pt: No. (Dr. looks through chart.)

Dr: Ok, what about the blurred vision you had once before?

Pt: Uh, I'm seeing a little double again but mmm just every once in a while. My head hurts me. . . .

Dr: And, you're staying on your diet? (She grins. He is still looking at chart.) You weighed two eighteen be-fore and now you weigh two twenty-one, you've gained three pounds. (She laughs throughout last sentence.)

Pt: I told you when you put me on a diet I was gonna gain weight. I told ya.

Dr: How're you gaining weight on a diet where you're not supposed to be eating as much.

Pt: Right, I don't eat as much, but I told you . . .

Dr: (breaking in) And that makes you gain weight.

Pt: No. Uh. It's, I don't know what it is. I know every time that a doctor has put me on a diet, and I really follow the diet, I gain weight. And I really gain it too. I'm
surprised I haven't gained more weight.

Dr: Do you drink more water than usual (Pt: Uh) when you're on a diet?

Pt: Yes. I drink alot of water.

Dr: More than usual now.

Pt: More than usual 'cause I usually don't drink, I'll drink, I might drink one glass of water a day.

Dr: Because that's probably what's going on see, you're drinking alot of water, you're getting alot of fluid retention which we can take care of easily with a fluid pill. (Pt: Mm hmm) Well have I given you, I haven't given you any fluid pills have I?

Pt: I don't think so.

Dr: Well you might have lost some weight but you've gained, you have fluid, you know, and we can give you, I gave you one back here (found a place in the chart), a little tablet you took every other day. You still taking it?

Pt: Mm hmm.

Dr: You're taking Oretic and you still gain weight, ok.

Pt: It's a problem.

Dr: Ok, now, what about the pain in the bottom of your stomach? Do you think that's any better at all?

Pt: No.

Dr: That still hurt just as much.

Pt: It, it still hurts. . . .

Dr: Have you been coming in getting your treatments to abdomen, diathermy treatments?

Pt: I missed two, but uh there was a reason I missed two.

Dr: Mmm, let's see. (He reached over and pushed on her lower abdomen.) Does that hurt when I press in there?

Pt: Yeah.

Dr: Real, still real tender huh? That still hurts. Are
you still real nervous? (Pt: Mm hmm) Still having crying spells?

Pt: Yeah. . .

Dr: OK. Let's see, you and your husband together? (She shakes her head no.) Separated? (She shakes her head yes.) How long you been separated?

Pt: Since March.

Dr: Since March. You planning on getting divorced?

Pt: I hope so.

Dr: Have you filed for divorce? (She shakes her head no.) Is your husband uh, why'd you say you hadn't uh, uh tried to get a divorce yet?

Pt: 'Cause I didn't have the money.

Dr: You didn't have the money. So there's no hope of reconciliation?

Pt: No.

Dr: Absolutely?

Pt: None.

Dr: You all have children? (She shakes her head no.) No children. Ok. Do you work or what? (She shakes her head no.) Where do you get money from? You on welfare?

Pt: Mmm hmm.

Dr: Ok. Have you got your Medicaid card too? (She shakes her head no.) You haven't gotten it yet. Do you get food stamps?

Pt: Mmm hmm.

Dr: Have you seen the lady in mental health care?

Pt: No.

Dr: Well, you don't want to see her?

Pt: No, I don't want to see her.

Dr: Why you don't want to see her, talk to her?
Pt: Cause I'm afraid she might find something wrong with me.

Dr: Like what?

Pt: Like maybe I need to see a psychiatrist, and I know I don't want to see one.

Dr: Ok, why do you think people see psychiatrists?

Pt: Because they need help. (laugh) They have a problem.

Dr: Do you think you have a problem?

Pt: I know I have a problem. I just don't want to see anybody about it. I, I'm trying to work it out myself.

Dr: Ok.

Pt: Why, do you think I need to see one?

Dr: Well, I'm gonna leave it up to you, you know. Uh, if you want to talk to a . . .

Pt: I asked, I asked you though, did you, in your opinion do I need to see one? (Dr: Mm?) In your opinion do I need to see one?

Dr: Yeah, I think you oughta talk to the uh lady in mental health. All she's gonna do is talk about your, your various problems.

The details of the doctor's interpretive work can best be presented by applying to this case the experimental findings reported by Garfinkel (1967:89-94) regarding the practices of the documentary method.²

1. Garfinkel describes the first practice as follows: "Answers were perceived as 'answers-to-questions'" (1967:89).

a) This practice means that Dr. Glass saw Ms. Franklin's remarks as motivated by his own questions. Whatever her responses were, he read them in light of the purpose he intended to express in his own
question. To draw out one specific example, consider again the following exchange between them:

Dr: Is your husband uh, why'd you say you hadn't uh, uh tried to get a divorce yet?

Pt: 'Cause I didn't have the money.

Dr: You didn't have the money. So there's no hope of reconciliation?

Pt: No.

Dr: Absolutely?

Pt: None.

During my interview with the doctor, the following interchange occurred:

I: What uh, what was behind your asking her about her separation from her husband?

Dr: See how she reacted and just get her to discuss it, get her to talk about it, see how much it's affecting her. Uh, you can find out a lot about a patient when you ask 'em and uh sometimes you ask 'em about it and they get angry.

I: What did you think her feeling was when you asked her?

Dr: Uh, what huh, when I asked her about the reconciliation when she said no, no, not, not at all, that she's not even thinking about it. So she had some anger and hostility toward the person she's separated from. At the same time, she's depressed because of the failure of the marriage, you know.

Based on his typification regarding how patients respond to questions about divorce—i.e. that they supply a good deal of information ("You can find out a lot") and that they often "get angry,"—Dr. Glass has asked Ms. Franklin about her separation from her husband and the possibility of reconciliation. He treats her response "No" as directly related to his question—No, there will be no reconciliation, she is
"not even thinking about it." Furthermore, in light of what he sees as typical emotional loadings on this matter, he takes her response as indicating "anger and hostility" toward the "husband" he mentioned in his question, i.e. toward "the person she's separated from." Dr. Glass, then, has seen Ms. Franklin's answers as referring to the topic he raised in his questions and in addition, as expressing the kind of emotion he was looking for when he asked the questions.

b) Hearing answers as answers-to-questions means also that the doctor heard what was intended, not simply what was uttered. In the excerpt discussed in a) above, we saw how Dr. Glass filled in the emotional responses (anger and depression) he regarded as intended by her in her answer, even though such reactions were not expressed verbally. Hearing the intended answer as opposed to the uttered answer can also be illustrated in their exchange regarding the episode at her father's house:

Dr: Were you unconscious?

Pt: I just passed out.

I asked Dr. Glass about her response:

I: When she said that she had passed out, what did you take that to mean?

Dr: Uh, I didn't think it meant anything physically that much but just part of her anxiety-depression she's going through, you know. So I didn't, you probably wondered why I didn't question more about it and all that (unintelligible) lab work and all like this, I just . . .

I: No, I didn't. No, I just wondered uh if, if you took that to mean that she actually lost consciousness or . . .

Dr: (interrupting) No, I didn't think she did. I just
think she probably just had a sort of a mild hysterical kinda reaction, knowing the patient as I did.

Ms. Franklin did not say, "No, I did not lose consciousness." But, based on his background knowledge of her ("knowing the patient as I did"), he has taken her remark "I just passed out" as indicating no loss of consciousness but rather an hysterical reaction, another sign of her depressed condition.

2. The second major finding reported by Garfinkel is that questions were not formulated in advance. Rather, they were formulated on the basis of "the retrospective-prospective possibilities of the present situation. . . ." (1967:89).

a) As a result of interpreting retrospectively and prospectively, a present answer can alter the sense of a previous answer. For example, when Dr. Glass pressed Ms. Franklin's abdomen, he asked, "Does that hurt when I press in there?" and she answered, "Yeah." Later, he explained to me that this response at first led him to believe that "her tubes were inflamed." On the basis of his stock of knowledge he holds as a physician, he judges such pain to indicate "pelvic inflammatory disease." However, he went on to ask her if she were "still real nervous" and she replied, "Mmm hmmm." This answer cast into doubt the sense he had made of her previous answer about abdominal pain. He said, "With a patient like her with all these emotional overlay, you can't be certain whether it is [pelvic inflammatory disease]."

b) This practice signifies also that the doctor engages in a search for meaning through such methods as asking the patient further questions to find out what she "has in mind" and by looking for meanings
that were not manifest in the direct answer to the question but could be seen as intended. We can see this aspect of the doctor's interpretive work in his pursuing with further questions the meaning of her response, "No, I don't want to see her" (i.e. the "lady in mental health").

Dr: Why you don't want to see her, talk to her?

Pt: 'Cause I'm afraid she might find something wrong with me.

Dr: Like what?

Pt: Like maybe I need to see a psychiatrist, and I know I don't want to see one.

Dr: Ok, why do you think people see psychiatrists?

Pt: Because they need help. (laugh) They have a problem.

Dr: Do you think you have a problem?

Pt: I know I have a problem.

After this sequence, the patient responded with a series of questions asking for the doctor's opinion on the matter. When I asked for his comments, he replied by referring to the intentions and needs he saw lying behind her requests:

Dr: Well she, uh, wha, to me when I get to a point with a patient like that, I feel like I'm making progress because uh she was willing to accept medical advice, you know. And, but yet I was trying to get her to make the decision on her own which is almost, al, also better, but she is a uh person of uh that needs uh, wants direction from her physician as to what's the best thing to do.

c) This practice is further manifest in the doctor's effort to elaborate an underlying pattern over the course of the exchanges, accommodating it to each answer. The underlying pattern Dr. Glass used as a
scheme of interpretation was that Ms. Franklin is a "typically depressed, over-weight patient." Her passing out was seen as "part of her anxiety-depression she's going through." Regarding her blurred vision, he said, "I think it's part of her depression and anxiety right now." He elaborated the pattern with regard to her obesity and her problems with her diet in the following manner:

Dr: You get poverty, uh then the patient gets depressed over the poverty, uh then you get to where they overeat to get some kind of enjoyment out of life.

The pattern is also made relevant to her abdominal pain. He stated during his interview with me:

Dr: She was so tense and emotional, that's why I can't really decide on her pelvic examination how much of this is emotional tension, you know. Like, the medicine we gave her for it, she threw that up. Look like she wants to be ill.

3. A third finding by Garfinkel concerned practices involved in handling inappropriate or contradictory answers. One practice was discussed in the last chapter. That is, when patients were faced with comments from the doctors that appeared to be at odds with their own assessments of a situation, they handled this contradiction by imputing special knowledge to the doctors. In this way, incongruities were resolved. Another practice entails constructing a scenario that will take into account both sides of a contradiction in viewpoints and propose a third factor that will resolve the incongruity. In the case of Dr. Glass, he was faced with the task of handling Ms. Franklin's response that she had in fact stayed on her diet and yet gained weight. Dr. Glass regarded this set of circumstances as "physiologically impossible." In order to resolve the contradiction, he explored with her the
possibility that the weight gain was due to fluid retention. As he explained to me:

Dr: It's physiologically impossible for her to be gaining weight, if that's what she's eating. And uh, course like I mentioned that she was drinking, alot of people you encourage them to drink alot of water uh when they're on a diet because uh you need it to get rid of the water, you know (I: Mm hmm) and it keeps 'em from being hungry. This is why I asked her about the fluid pills if she'd taken one every other day I might decide to give her one every day to see if she does have a maybe ten pound of fluid retention. And once you get that ten pounds off it does encourage them a little bit. It's possible that she could be on a diet but she drinks alot of water and she gets fluid retention.

4. Garfinkel depicts another practice as follows: "In their capacity as members, subjects consulted institutionalized features of the collectivity as a scheme of interpretation" (1967:92). That is to say, the doctor questioned Ms. Franklin about such "features of the collectivity" as marriage, divorce, children, and financial status in his effort to make sense of the patient's condition. Dr. Glass has tied these into various other social structures (the church, racial groupings, age groupings, work) to construct a grand theory that serves as an explanatory device for the sundry ills he treats:

Dr: Well first you get the poverty which causes the family breakup. Then you get depression behind that. And then there they are, they're separated, divorced, or widowed and all they have to do is eat. So they eat and they become obese. Uh and with obesity this causes physical ailments such as diabetes, hypertension, high blood pressure, heart disease. And then they go from that into a more vicious depression. And its a vicious cycle. And I have what I call a Christian obesity syndrome.

I: Why do you call it a "Christian" obesity?

Dr: Because its uh, uh, specially in the Black
community, you find that the church is the center of the social outlet, specially for the female in the older generation, this is what's happening now is that the younger generation has a different life-style. But the whole thing boil, centered around uh working all day six days a week and then going to church and meeting friends. And uh, then uh, come home and eat fried chicken for the Sunday dinner, inviting all the re, relatives in, neighbors in, and uh, uh, really they get to where the, the man in the family to, maybe through poverty or noneducation or not being able to fit in with the system, is not able to provide the monetary support for the family. So the wife turns to the church for the, the father-figure or the man-figure. And, the more she turns that way, then she doesn't support her man. And uh, one psychiatrist has referred to when uh Blacks go to church they'll have a orgasm, I mean a shout, a Black psychiatrist from Howard calls this a religious orgasm. As a substitute for a sexual orgasm with a a man that she support. And uh they go right back into the week, you know, uh, and it just becomes a vicious cycle and its, they'll go to mission meetings, et cetera and uh now what's happening now, this is why they say that the suicide rate among, among Black females is on the rise because they no longer have the church as a sanctuary, to protect them from what's going on. And specially in the larger cities. But then uh, in the typical Black towns you'll find that everything centers around um church life, and uh they tend not to do for themselves, but they rely upon, they become overreactive toward religion thinking they can solve all of their problems through relating to other people instead of trying to solve their own problem of overweight, by not eating, et cetera. Uh, they uh try to use religion to solve every problem they have. And uh this is how I, I call it the Christian obesity syndrome. And uh you find it time and time again, you say "Do you go to church?" "I go every Sunday" you know, and uh, so uh, this is the biggest problem uh that we run into here in this clinic, you know.

5. The final practice Garfinkel found regarding the documentary method of interpretation consisted in deciding the warrantability of an assessment by assigning to it a perceivedly normal sense. This practice is discussed throughout the next chapter and so, for brevity's sake,
will not be detailed here.

In this description of the practices involved in the use of the documentary method, we have seen how Dr. Glass, as did Dr. Ferguson, treated the patient's symptoms as standing on behalf of an underlying pattern assembled on the basis of three sources. He drew on his background knowledge of the patient, indicated in his phrase "knowing the patient as I did." He drew on general typifications, such as how patients respond to questions about divorce, how poverty and divorce lead to depression and overeating, and how Black females relate to the church. And he drew on his medical expertise regarding hysterical reactions, abdominal pains, fluid retention, indications of depression, and so on.

The three essential features of the documentary method pointed out during the discussion of Dr. Ferguson's diagnostic procedure are also present with Dr. Glass's. First, the relationship between the observed appearances and the underlying pattern is one of mutual elaboration. Dr. Glass understood Ms. Franklin's symptoms of passing out, blurred vision, obesity, and abdominal pain as evidences of a depressed state. At the same time, those symptoms were clues to her depressed condition.

Second, as a consequence of this mutual determination between symptom and underlying pattern, a change in one will lead to a change in the other. We can see this feature clearly in the following exchange that occurred during my interview with Dr. Glass:

I: What did you take it to mean when she said that she was still having double vision, or seeing double?
Dr: Uh (pause) I think it's part of her depression and anxiety right now. When she first came in, you noticed she was on quite a bit of medication and we stopped 'em all and alot of her dizziness went away. When we first saw her. But we were, wha, uh, if she persists in this, we'll check it out at the eye clinic.

Thus, at the present time, her blurred vision is understood as one aspect of her depression. Formerly, when the underlying pattern was not depression but was over-medication, her blurred vision stood as an indication of a side-effect of the set of drugs she was taking. In the future, it may be seen as evidence of troubles with her eyes. The "same" symptom is read in different ways, depending on the nature of the pattern being elaborated. Moreover, some change in the symptom (e.g., its alteration from a short-term problem into a persisting one) brings about a change in the pattern to which it serves as a clue (e.g., a change from depression to visual difficulties).

Third, the interpretation becomes objectified such that the formulation arrived at by the doctor is seen as inhering in the nature of the case, not in his evaluative work. This projection is evident at the close of Dr. Glass's presentation of his theory of the Christian obesity syndrome when he said, "This is the biggest problem uh that we run into here in this clinic, you know." That syndrome is treated as "out there" to be "run into" and is not seen as a function of or as a product of his own assessment of his cases.

The process followed by Dr. Ferguson and Dr. Glass was not unique. The use of the documentary method in diagnosis was found in every interview. To be sure, there were differences, but these had to do with the content, not with the method. That is, the content of the
sources used by the doctors in assembling the pattern varied with each case. Thus, the ethnographic details composing the doctor's background knowledge were not always based on previous personal encounters with the patient as patient. Doctors also drew on reports in the chart, comments from other personnel of the clinic, observations of the patient in the waiting room, brief conversations held in the hall, and so on.\(^3\)

The content of typifications also varied. Three examples will be given of typifications used in interpreting symptoms. The first example is from a report by Dr. Dudley:

Dr: Most patients—especially women—will call most headaches migraine and (laugh) if they have them constantly they say they have migraine. . . . There are about 700 causes of headaches so (laugh) they don't all have to be migraine.

This typification instructed Dr. Dudley not to take at face value his (female) patient's report that she suffered from migraine headaches. Since most women count most headaches as migraine, and since there are many other causes for headaches, this particular patient may suffer headaches from one of those other causes.

Another example of a typification is found in the following exchange with Dr. Branch about Ms. Pilot:

I: What were you after when you asked her what time of day her lip-quer occurred?

Dr: I wanted to, first of all, to try to find out whether there was any uh uh, not rhythm so to speak, but uh time relationships particularly to uh what she might be doing at certain times of the day. Particularly uh uh frequently in if it's a neurotic complaint, then you would find that there might be a relationship uh between uh her activity of the day and the uh relationship of her symptoms. Particularly during times of inactivity you know, when the patient becomes more inward and when they start uh being a little more conscious of uh themselves you know, so to speak, as opposed to when they're
busy and going about doing the routine things and
noticing that they have a lack of symptoms then, you
know.

Here the doctor was attempting to measure the accuracy of Ms. Pilot's
report of the persistence of the lip's quivering against what he re-
garded as a typical time when it is possible for patients to become
aware of such a symptom.

A third example is drawn from the conversation with Dr. Scott
concerning Ms. Kinkaid:

Dr: She said she has no more itching. So apparently ... 

I: Did she at one time?

Dr: Uh, I am not sure, I would have to look at Dr. uh Dr.
uh, go back and look at Dr. Robert's note where, under
the "objective" she, he would have uh said mmm "has
vaginal itching" or "urinary buring." On the other
hand it might be meaningless. She might have denied it.
A lady of her age, she simply is not content to be found
with bacterial infection of her urinary bladder and
vagina, which she might be connecting to V.D.s.

This typification of what might motivate the answers of middle-aged
women was taken by Dr. Scott as an instruction to regard the responses
of his patient as possibly "meaningless."

This finding regarding the diversity of the typifications holds
even when the surface form of two typifications is quite similar. That
is, two statements which appear to typify a person or situation in the
same fashion turn out to provide different meanings for the doctors when
applied to specific cases. For example, in the case presented earlier,
Dr. Ferguson applied to Ms. Brown a typification stating that most pa-
tients "wouldn't have gone to the doctor" with the sort of dizziness and
headaches she reported and that they do so because the clinic provides a
place "free of charge" where they can get some attention. Dr. Dudley
worked with a typification similar to Dr. Ferguson's in its superficial
structure when he dealt with Ms. Perkins. During our interview, he
said to me:

Dr: She said she lives alone. From what her symptoms were
today, she probably really didn't even have to come
back to the clinic. If she had been going to a private
doctor, she probably would not have gone back. But
these people need some outlet and alot of 'em look upon
the clinic as just an outlet for some of their loneliness. . . . She just needs to talk to people and be asso-
ciated with people and they find this is a good sounding
board for things like that. We probably see alot of
patients who actually don't need to be seen right then.

Both doctors have described their patients as the typical case of "just
needing to talk to people" and using the free availability of the clinic
as a "sounding board for things like that." But what this classifica-
tion signifies differs for the two doctors. The implication Dr.
Ferguson draws from this typification is as follows:

Dr: I don't think this requires doctor-time, you know for
a work-up. It would require, as all of our patients
would, social-work help and what not, related to her
family and everything. But we don't have it to offer,
and so I don't pretend that uh, I don't get real in-
volved and pretend to the patient that I'm gonna be
able to take care of those problems, 'cause I'm not,
and I'll just end up hurting them if I lead them to
believe I am.

Dr. Dudley's remarks contrast with Dr. Ferguson's:

Dr: Patients who come because they need an outlet, well
that's as much a part of therapy as when they have
actual pains and what not 'cause when you get into
psychosomatic medicine, alot of their ailments and
what not are not organic, they are emotional and
everything else. So if you start trying to weed
'em out, you'll find you are really doing more harm
than good because even though she's probably need-
ing nothing for any organic reasons right now, at
least she probably feel better that she has talked.
So you can't just write 'em off and say they're gold-bricking 'cause they have a need.

Examination of these two sets of comments reveals that when Dr. Ferguson classed his patient as one of those "just needing attention," he took the typification as signalling a strategy of withdrawal on his part in order to avoid raising false hopes in the patient about the amount of aid he could give her. Becoming involved in such cases would "just end up hurting them." In contrast, when Dr. Dudley applies this typification to his patient, he means to imply a need which is just as medically legitimate as "actual pains" and regards his talking with her as "at least" making her "feel better." Trying to remain uninvolved in such cases would be "doing more harm than good." The point at issue here is that all the doctors used typifications in their efforts to interpret their patients' symptoms, but that the substantive content of these typifications varied. I gave three examples of this diversity and then explained that even in those instances when the "same" typification was used, variations entered via the specific sense it had for the doctor who applied it.

Just as there was diversity in the ethnographic details composing the various doctors' background knowledge and in the form and sense of typifications, there was diversity in the specific items from the body of medical knowledge which the doctors brought to bear in each case. They varied according to what the doctor was making of the symptoms presented to him. To repeat, these variations in the substance of the sources used to construct an underlying pattern did not affect the essential workings of the documentary method and its primary features.
Thus far, the discussion of the diagnostic procedure has consisted of showing that the doctor made sense of his patient's symptoms through the documentary method of interpretation. That is, he treated the symptoms as evidence of an underlying pattern assembled on the basis of what he saw the symptoms could mean in light of such considerations as his background knowledge of the patient, his store of general typifications, and his stock of medical information. At the same time, which aspects of these considerations were construed as relevant—i.e. what sense they had for a particular case—depended on the specific symptoms presented by the patient. But still to be shown are the fine details of the interpretive work whereby the doctors used these considerations as guidelines in assembling the underlying pattern, i.e. how they accomplished a connection between these general guidelines and the actual case at hand. Analysis of the data revealed that the practices involved in this articulation bear a strong resemblance to the ad hocing practices found by Garfinkel (1967:18-24) in his examination of the ways in which his graduate students coded data. These practices were seen to be invariant and necessary considerations for coders to decide the fit between what could be read from the data and what they entered on the coding sheet. In other words, the ad hocing practices constituted the judgmental work of following a set of coding instructions so as to assign data to one category rather than to another. The doctors faced a similar task. Following a set of guidelines—guidelines drawn from his background knowledge of the patient, from typifications, from his medical expertise—they had to pattern the particulars of a given case in such a way that one diagnosis was indicated rather than another. The
ad hocing practices they used to accomplish this task are discussed below.

**Et Cetera:** There are unknown elements which fit under the guidelines though they are not explicitly listed. That is, an assumption is made that the guidelines do not inventory every item they cover. Consider Dr. Dudley's discussion of Ms. Rankin:

Dr: Often when you find people with so many complaints and have kids, they develop, in fact I started to ask her does noise bother her, but if her youngest child is thirteen, she probably doesn't have little kids running around that makes some women climb the walls. With all her complaints and her husband being a disabled vet, she's probably pretty well upset. One of the diagnoses I put in the form was "anxiety reaction" because of all these things, and she probably likely does have some nervousness. She's definitely anxious. And some other doctor had recognized that and recommended psychiatric evaluation.

According to his guideline, people with numerous complaints who have young noisy children frequently develop an anxiety reaction. Now, Ms. Rankin does not have young noisy children. She does have a handicapped husband. While that item was not explicitly listed, his general rule was seen to cover such an eventuality. For, handicapped husbands can upset an ill woman just as noisy children can. So he gave her a diagnosis of anxiety reaction. The practice of "et cetera"—treating a previously unspecified feature (handicapped husband) as nevertheless falling under the rule—has made it possible for the doctor to link an actual occurrence with a general rule and count the diagnosis indicated in that rule as the diagnosis appropriate to the case at hand.

**Unless:** There are certain contingencies which affect the use of a guideline. Although these cannot be designated in advance, they
can be recognized when they appear. This practice is illustrated in the remarks by Dr. Glass concerning Ms. Franklin:

Dr: Usually when a patient says they're nervous, I'll fi, I'll ask 'em, "Well, what do you mean by 'you're nervous'?" And they'll either say something, they'll say that they shout at the kids. They very seldom say their hands shake. Uh, they get upset real easily. And then I try to get into the questions about, I either ask them, you know, do they have any problems sleeping, without directing the answer. And sometime they come right out and say, "Yeah, I go to sleep and I wake up at two and I can't go back to sleep," you know. Uh, some will say, "Yeah, I have a problem sleeping," and then I try to ask them do they have trouble going to sleep or do they wake up too early. Like I asked her when she woke up at six-thirty, did she have to get up. And she said no, she didn't have to, that she wished she could keep on sleeping. So this is what we call the depression-early-awakening-syndrome. Early awakening which is a sign of depression.

Here his general guideline states that patients who awaken early are suffering from depression. Two o'clock is early. But many people wake up regularly and necessarily at 6:30. His guideline does not apply to a person who wakes up at 6:30 unless that person does not have to or want to wake up at 6:30. Through the practice of "unless," 6:30 and 2:00 become essentially the same. In this way, the diagnosis of depression indicated in the guideline is made applicable to the particulars of Ms. Franklin's case.

Let It Pass: There comes a time when the open structure of the guidelines allowed by "et cetera" and "unless" must be limited. The task, after all, has to be accomplished. At some point, the doctor decides that enough of the expected features are present to satisfy him and he "lets it go." In the following excerpt, Dr. Branch is discussing Ms. Travis:
Dr: I examined her heart, lungs, abdomen, and she's tender in the chest area on the sternum where she's complaining she gets this tired feeling and soreness on her ribs under her breast and by palpating these regions, I can confirm that she is indeed tender which is good. I want to find that because then uh, you know, she is a candidate for developing, she has arteriosclerosis of, probably has some arteriosclerotic heart disease. Therefore she can develop an MI or infarct which might present itself with sharp chest pain, particularly on exertion and what not. But in this situation she's also got chronic arthritis and the thorax or the chest wall is tender to touch and this would not go along with findings of chest pain coming from the heart. Although she might have episodes of angina. But I don't think so. This is a lady that, you know, wherever you touch her usually she will have some soreness and tenderness so she's hard to evaluate. She is difficult.

Dr. Branch considered the possibility that Ms. Travis's pains on the one hand might be due to arteriosclerotic heart disease and associated infarcts or angina. On the other hand, the pains might be due to arthritis. As he said, the case is "hard to evaluate" because she has some features indicating one diagnosis and some indicating another. At the close of his interview with Ms. Travis, he had to complete his task by specifying and prescribing something. So he "let it pass" that she had enough of the characteristics of arthritis to allow for that diagnosis and prescribed aspirin as the effective treatment for her now established arthritic pains.

_Factum Valet_: An occurrence otherwise prohibited by a guideline or not predicted by a guideline is counted as correct and coming under the guideline if it happens nevertheless. In the example given here, Dr. Roberts is answering a question concerning Mr. Rodriguez:

_I:_ You asked him what time of day he had the dizziness. Why did you need to know that?

_Dr:_ I was trying to relate that as to when he had it with, in
relationship to when he took his insulin. If he had the dizziness right after taking the insulin, then I would probably think that he was getting maybe too much insulin, or the insulin was causing him to have a sudden drop in his blood sugar and then would come back. But he said that he had it at two o'clock in the afternoon. Uh, I don't really think it had that much of an association with the 40 units he had at eight o'clock that morning because the 40 units should have started pretty much wearing off by then.

At the end of his visit with Mr. Rodriguez, Dr. Roberts explained to him that his dizziness was in fact due to an inadequate supply of blood sugar brought on by his insulin injections and he told his patient to eat food containing sugar when such episodes happen. Thus, even though the doctor's guideline instructed him that insulin taken at 2:00 in the afternoon would be "pretty much wearing off" eighteen hours later and therefore not causing dizziness at 8:00 in the morning, still the dizziness has occurred. The practice of "factum valet" means that this un-predicted occurrence was counted as covered by the rule and the diagnosis indicated therein is allowed to stand.

These ad hocing practices, then, are used by the doctor to grasp the relevance of his general guidelines to the actual situation they are intended to analyze. He consults these practices in order to recognize what the guidelines really and definitely mean. In this way he constructs a context judged as suitable to, as taking proper account of, both the general rules he goes by and the specifics of a presented case.

A question may be raised at this point regarding more "objective" measures of disease. That is, does not the use of diagnostic tests eliminate the necessity for much or all of the "subjective" work we have been documenting throughout this chapter? In a word, the answer is no. Consider, for example, the following remarks by Dr. Scott concerning
the reports from the laboratory ordered for Ms. Kinkaid:

Dr: There were two, two, there were three, three sugars and I, there were three sugars. One was uh a hundred and ten, the other one was eighty-five, and the last one was hundred and sixteen. That's all mm just at threshold uh uh for, slightly raised value of uh fastning blood sugar. Uh, however I noticed . . . that she has uh in her microscopic urine white blood cells too numerous to count and extremely, and now I think about thirty to sixty or fifteen to thirty of red blood cells . . . and uh mmm the last is bacter, mmm again, bacteria too numerous to count plus trichomonis vaginalis which uh occurs in, which will be either there as a contaminant from the vaginal discharge she had . . . but I still don't, that would, that wouldn't have made any difference. They also can exist in the, in the urinary bladder. . . . There is one thing which occurred to me at that time when I was mm harping on her lung disease, is why does she have an emphysema. She says she has it only one year. You see, emphysema should have an etiology, there is, there are emphysemas which are idiopathic. There are emphysemas which are due to bronchiectas, you see, you might have noticed that I have looked in a text book. Uh, uh, I wanted to, it occurred to me that maybe she has a polycystic kidney. I had a number of thoughts in this. Uh, with the fastning blood sugar I explained it to her that if she's spilling little bit of sugar she is feeding the trichomonis or the bacteria in her urine with that extra sugar. And she doesn't go, mmm, she doesn't urinate, number of thoughts, combinations I made out of this, just looking at those tests. . . .

I: So just from the tests, they didn't really settle alot for you? You still had to, you still had some questions that those tests. . .

Dr: I had many more questions.

It is apparent here that the results from tests cannot stand alone anymore than can a symptom. These too must be embedded in a context. Dr. Scott's remarks point up the fact that a variety of stories can be spun around a set of reports from tests given in the first place as a way of resolving ambiguity. That is, Ms. Kinkaid's tests resulted in numbers indicating slightly high amounts of sugar in her blood and the presence
of bacteria in her urine. This set of reports could indicate diabetes and a urinary tract infection, or diabetes and a vaginal infection which has contaminated the urinary tract, no diabetes but enough surplus sugar being excreted to feed bacteria in the bladder, or a polycystic kidney possibly connected with her emphysema and resulting in insufficient absorption of the sugar in her blood, insufficient urination, and therefore growth of bacteria. The significance of the numbers depends on the context in which they are embedded.

A report from the laboratory, then, is just one more particular in the overall situation the doctor must render sensible. Indeed, it is often the case that the report is interpreted in light of the sense the doctor already has made of the circumstances that confront him. An excerpt from Dr. Warren's statement about Mr. Shore illustrates such a case:

Dr: The poor fellow has atypical TB and this TB is very fascinating because it was missed. I suspected it. We sent him to Clay Hospital. We got the sputum. But we kept missing it until he got tired, I got tired, and I said, "Let's put you in Tyler and get more tests." Dr. Doyle at Tyler called me and told me the culture grew an atypical bacillus. . . .

I: When the tests from Clay came back negative, why did you continue to . . .

Dr: That's a good question. Because Joseph kept with coughing, weight loss, temperature, weaker. So the weakness and the coughing and weight loss and temperature, and I said, "Let's give it another try." Because the sputum we collect and send to Clay is three morning samples. Now if he'd got admitted at Clay they might have got what Tyler got. But he said, "Let me go to Tyler—a new setting." So I said, "Alright."

Dr. Warren repeated the test until he received a result he saw as correct given what else he knew—about his patient, about various hospitals,
about the effect of a change in settings, and so on. The point here is, not that tests are useless, but that they are no remedy for interpretive work. That work is required in order for the doctor to prescribe a given test and then to construe its results. The case furnishes the ethnographic details to form the context to interpret the test. The test in turn is used to inform the doctor about the case.

In this chapter we have examined the way in which a doctor comes to see a symptom as indicating a specific condition. We saw that a symptom is essentially ambiguous until he embeds it in a context assembled on the basis of background knowledge of his patient, typifications of patients in general, and relevant items from his scientific training. By using ad hoc practices, the doctor is able to match these general criteria to the specific occurrence before him.

We have found, then, that the doctor's classification of a patient's symptoms as an instance of a particular disorder is not based on a limited set of specifiable features of the disorder. Rather, the classification depends on indefinite features of the situation which the doctor works to structure into a definite pattern, a pattern that derives its meaning partly through the feature it is meant to interpret. Moreover, though the patient's symptoms on a given occasion may be diagnosed as signifying some particular illness, this diagnosis is revisable on the basis of later events or further information.

Consequently, in order for a doctor to recommend his diagnosis to his colleagues or to any observers, he must evoke in them the context from which he worked so that they will see the case in the same light as he does. In addition, he draws upon such considerations as "given
the limited amount of time available for each patient" or "given the facilities available at this clinic" to establish the warrant for his findings. It is to these practices of establishing warrant that we now turn in the next chapter.
CHAPTER SIX

MAKING THE ENCOUNTER RATIONALLY ACCOUNTABLE

As was pointed out in Chapter Four, a major facet of common understanding is that each participant of a conversation regards his own constructed context as the context for the talk. What he has made out of the utterances is not treated as one of two versions, but rather as the "real" meaning that was intended. In Chapter Five, we saw this same objectification occurring when the doctors regarded the sense they had made out of a series of symptoms as "out there" for them to find, as inherent in the indications given by the patient rather than in their own assessments. How is it that the doctors and patients come to recommend their own assessments of the situation? What grounds do they cite in presenting their assessments as competently done and their encounter as successfully completed? In discussing the documentary method of interpretation in Chapter Five, I noted that one of its constitutive practices involves this matter of establishing warrant, of deciding the rational character of deeds and judgments. The present chapter will detail that work.

Before addressing the primary topic, however, I wish to make two points regarding the evaluative reports given me by the participants. First, giving such reports is not an unfamiliar task to them, for both doctors and patients routinely have occasion to appraise their encounters—and to state that appraisal. For his part, the doctor
attends frequent meetings with the staff of the clinic at which his cases are discussed. He also is involved in more informal consultations with his cohorts regarding his assessments of his work. Still further, he faces periodic reviews by officials of the governmental agencies which fund the clinics. These officials examine the actual contents of the doctor's files on his patients and report on the propriety of his decisions and strategies. On all these occasions, the doctor is called on to justify his course of action with regard to his patients and to show himself as competent, efficient, and correct.

Patients, too, give evaluative reports. Though they are evaluating what has been done for them rather than by them in contrast with the doctor, still they are giving the encounter critical review. Patients discuss with one another the merits of their treatment. They recommend (or do not recommend) a given doctor to their relatives and friends. Moreover, there are times when they report their estimations to the personnel of the clinic on a rather formal basis. One such time occurs when they are asked to complete questionnaires concerning the staff and procedures of the clinic. Another occurs when they ask to be transferred from one doctor to another. In these circumstances the patients are frequently urged by the former doctor, by the requested doctor, or by the nurses to state their reasons for seeking the change. In the case of the patients, then, as with the doctors, it was no new task I required of them in our interviews when I directed them toward an evaluation of their session.

The second point to consider relates to the first. That is, since these evaluations are given by the doctors and by the patients in
several different settings, the reasons they give for their assessment of an action in a given situation may vary with each setting. Their story may change with each telling. For, the reasons they give are undoubtedly formulated with an eye toward what they believe a particular audience will accept as reasonable. From the standpoint of some practical endeavors, this state of affairs poses a critical problem. For example, suppose a doctor prescribed a certain drug and explained to the staff of the clinic that he ordered the drug because it was the one best suited to return his patients to health. He told his stockbroker that he has been prescribing the drug in order to increase the profits of the company that synthesizes the drug, a company in which he has a substantial investment. Now from the standpoint of the patient, it is of signal importance which of these reasons was the "real" one. But from the standpoint of the present analysis, attention is focused on the grounds he cited in either case to recommend the good sense of his action. Thus what is of interest is the finding that the grounds on which he based his argument both to the staff and to the stockbroker were the grounds of technical efficacy. To both he explained himself as having employed the best means to achieve his stated end. For the purposes of analysis, it is of no import that in one case the stated end was the patient's health and in the other, the doctor's profits. We want to know not what he said his reasons were, but on what grounds he recommended his reasons. We want to know how, on any occasion whatsoever, actions are assigned their status as rational and sanctionable and thus how people accomplish the rational character of their actions. In our examination, then, of the interviews with the doctors and
patients, we shall be looking for the way in which they displayed the justifiably competent character of what had passed between them. My analysis will show that the doctor and patients established warrant for their assessments and actions by "assigning"\(^1\) to these assessments and actions a "perceivedly normal sense" (Garfinkel, 1967:93). That is, the task was recommended as having been capably accomplished on the grounds of typicality, likelihood, comparability, causal texture, technical efficacy, and moral requiredness.

**Typicality:** A given patient, doctor, or situation was treated as an instance of a larger category of patients, doctors, or situations.

**Likelihood:** Patients and doctors portrayed their actions as having been taken in light of the probability of some specified occurrence.

**Comparability:** Behavior was seen as warranted by establishing it as comparable to behavior in the past or planned—for future.

**Causal texture:** Doctors and patients assigned warrant to a course of action by describing the conditions under which it occurred.

**Technical efficacy:** Actions were depicted as justified and justifiable on the grounds of their effectiveness in achieving some stated goal.

**Moral requiredness:** Some actions are described as necessary solely on the grounds of rectitude and are held as unquestionably required regardless of personal desires and regardless of how they might be assessed on the basis of typicality, likelihood, comparability, causal texture, or technical efficacy.

It will be seen that, in assessing any single behavior, the
doctors and patients may use all six of these grounds, only a few, or just one. Further, when several of the values are involved, the result of the assessment need not be consistent across all of them. For example, one of the doctors explained that diseased gums typically cause headaches but had not likely done so in the case of his patient. Moreover, the grounds may conflict with one another, as when a doctor described his treatment as technically inefficient in achieving a cure but prescribed nevertheless because of a moral requirement not to rob a man of all hope.

These features regarding the assessment of behavior—i.e. that the perceivedly normal values may be used singly or in groups, that they may result in inconsistent outcomes, and that they may conflict with one another—were also found by McHugh (1968). They are noteworthy in that the unstable and contradictory character of this work is a standard property of common sense reasoning. Although such features are seen as faulty when compared with the features of scientific rationality, Garfinkel\textsuperscript{2} has shown that the latter cannot be used in everyday life without disrupting social interaction.

The first set of examples will be taken from the interviews with the doctors. Within each excerpt, I shall designate the points at which the perceivedly normal values are assigned by printing in capital letters the given value involved. The example below is drawn from Dr. Dudley's account of his plans regarding Ms. Rankin. She had come to have a medical form filled out in order to establish her eligibility to receive welfare. In the course of their conversation, she told him that five years ago at the hospital associated with the
University of California, she had been diagnosed as having cancer of the colon. His remarks to me were as follows:

Dr: I want to go further (unintelligible) colon, and, and, check on that because uh just to turn somebody loose that has had diagnosis of cancer of the colon uhh, it

MORAL REQUIREDNESS
wouldn't, uh it really wouldn't be fair, and it

CAUSAL TEXTURE LIKELIHOOD
wouldn't complete our records. Uh I'm certainly sure that it's not cancer because she said it was over five years ago and the survival rate for cancer of the colon would hardly be that long, because if it was enough for them to pick up five years ago without any treatment or surgery or anything, she'd have been gone by now. So, I mean this is one thing that makes me pretty sure that it's not a cancer. And this is why, why

MORAL REQUIREDNESS TYPICALITY
I say I think it's a shame that some medical people will, will give patients these impressions.

Dr. Dudley justified his plan to look further into the possibility that Ms. Rankin has cancer of the colon on the grounds of fairness. Further, he cited the procedural requirements at the clinic to keep complete records as constraining him to follow such a course. While his assessment is that she probably does not have cancer, his decision is to play it safe, especially since it is such a "shame"—it is just not right—for a patient to have to think she has cancer if she really does not. Note in his final sentence his movement away from speaking about Ms. Rankin and her doctors in particular to the general case of "medical people" and "patients."

The second example is taken from Dr. Ferguson's report regarding Ms. Flowers. At the beginning of her conversation with the doctor, she complained of a sore throat and a sinus infection. After that problem
had been analyzed and prescribed for, she told him of a "little breaking-out" under her chin. He asked her some questions and then told her not to "dig in 'em" and to "scrub 'em real good." In his conversation with me concerning this portion of their session, he said;

CAUSAL TEXTURE
Dr: I didn't have time to really sit down and treat it as a long independent thing, and that was what I would do.

COMPARABILITY
And uh you'll find, you'll find that we do that alot and we, we have to. The reason we have to is 'cause it's not unusual to have a patient come in with eight or ten complaints.

CAUSAL TEXTURE
And there's no way to sit down and treat each one independently ... there were one or two little pustules which

TYPICALITY
you'll find on alot of people when you check, and all I'm

LIKELIHOOD
doing in effect is taking, let's suppose a hundred people come in with that same type problem. What in effect I'm doing is saying that if I just let it ride, only a small percent would go ahead and have problems and come back.

Here Dr. Ferguson was establishing warrant for his decision not to search out in more detail the nature of Ms. Flowers's problem. He characterized it as necessary, given the procedural constraints regarding time for each patient. His behavior was depicted as comparable to his (and other's) behavior in the past by citing it as a common practice. Besides, he said, having one or two little pustules is a typical condition and not likely to cause serious problems. He will play the odds on this one.

In the third example, Dr. Roberts is warranting his judgment that Mr. Rodriguez has been lying about staying on his diet and his decision not to confront him with this judgment.
I: He told you he kept a written record of everything he eats. Does he ever bring that in?

Dr: Yeah, but if I, but if I. No, well yes he does. He brings it in and gives it to the nutritionist. But

TYPICALITY if I'm exbezzling on my taxes or if I'm embezzling money or something like that, I keep a written record too that I turn in to pay my taxes with. It's not a honest record

LIKELIHOOD though, so that what he keeps doesn't necessarily have to match up with what he eats. (laughter) But I'm not going to say to him, "You're lying, I know you're not

TECHNICAL EFFICACY following your diet," because that would just antagonize

LIKELIHOOD him and then he would say, "Well I'll show that doctor, I won't take my insulin." And then he'll go into shock and they'll drag him into Miller and treat him for twelve hours and bring him back out and he'll go back in again

MORAL REQUIREDNESS in another week. Besides, you know, it's his life. If he wants to get off his diet and eat wrong and go into

MORAL REQUIREDNESS shock all the time, well, that's his prerogative. I don't like to pay for it, pay for having to treat it, but that's his prerogative.

Dr. Roberts recommended the sensible character of his judgment that

Mr. Rodriguez was lying by typifying the situation as one in which phony records might be an expectable and understandable occurrence. It was depicted as that kind of situation by drawing an analogy. Just as an embezzler falsifies his records, Mr. Rodriguez could be falsifying his. Then what he turns in on paper quite likely does not correspond to what he eats. Dr. Roberts advocated the suitability of his decision not to face his patient with this charge on the basis of two considerations. First, he cited its technical efficacy in avoiding a
probable and undesirable consequence. Mr. Rodriguez might be angered and, for revenge, omit his medicine and become very ill. Second, the patient has a right to live his own life. Dr. Roberts cited this right as proper grounds for his not trying to correct Mr. Rodriguez's behavior even though this course of action might lead to circumstances he personally did not like.

Dr. Hart's accounting for his course of action will be the fourth example. His patient, Ms. Granado, has had a blood test for syphilis and the report indicated the test was positive. Another doctor has ordered that her test be repeated, but at the time of her visit to Dr. Hart, the results had not been received.

Dr: The other doctor ordered the blood test repeated. But,

**COMPARABILITY**
I order them repeated too but I go ahead with the treatment even though the blood test is repeated. I've always

**TECHNICAL EFFICACY**
felt that it was for the benefit of society that all patients with positive VDRL under any condition should

**COMPARABILITY**
be treated. No exception to this rule with my way of practicing. You can repeat 'em or you can fool around with 'em or you can wait for 'em to be recorded or you can sen'em for titers or whatever you want to, but

**COMPARABILITY**
I always treat 'em, number one.

A "titer" is a test that indicates how many antibodies are present relative to the positive VDRL. Reports from the test are in the form of ratios. Dr. Hart has listed on her chart that her ratio is 1:1, even though the results of the test are not back.

I: Why did you put her down as 1:1?
Dr: It just means you can go ahead with the treatment.

CAUSAL TEXTURE
A person reading the chart will then have justification for giving the treatment.

As a warrant for his decision to proceed with the treatment prior to receiving the results of the repeated blood test, Dr. Hart pointed to the technical efficacy of such action in protecting the society from the disease. He also pointed to the comparability of his decision to past times by stating that he regularly proceeds in such a way, that he always "treats 'em." Recording in the chart the results of a test, the "titer," also not yet received, is regarded as necessary because of procedural requirements for treatment at the clinic.

The final example will be taken from the interview with Dr. Henry concerning Ms. Vaughn.

I: What did you have in mind when you said to her, "You're going to have to overcome your home situation"?

Dr: I had in mind getting her off of that, off of that uh, off of that, what was it she was takin'?

I: Librium.

Dr: Librium. I had that in mind, because I, I don't think, I don't think it's any point in, in just giving

TYPICALITY
patients like that Librium. It's almost like uh, uh, a farm, a pig get his head hung, hung in, hung between the fence rails, farmer tells you to go out there and get that, get that, turn that pig a loose. I'd go out to that little fella and get me a stick and whipping the pig. What I should have done is I shoulda lift, lift, lift the rail off the pig's head. And that's just the

TECHNICAL EFFICACY
point. You see, uh, this Librium, what, where is it gonna get us? This is a situation at home. She said that the chi'ren drove her crazy. You heard her say, that, actually
TYPICALITY

it's a, that's a situation where alot of these people are in ... these people have family affairs, they have economic problems, and money matters, and all that kind of stuff. You see?

Dr. Henry gave warrant to his decision to withdraw Librium from Ms. Vaughn by establishing her and her situation as representative of a certain type. He likened the situation to one in which a pig is hung in a fence. That is, something needs to be done to alter not the pig, but the state of affairs. He classified his patient as an instance of "these people" who have various socio-economic problems. Note his movement from referring specifically to Ms. Vaughn's home situation, "she said that the chi'ren drove her crazy," toward the general case, "that's a situation where alot of these people are in." He also justified his action on the grounds of technical efficacy. Since use of the drug will not achieve his desired objective of actually alleviating her difficulties (lifting "the rail off the pig's head. And that's just the point."), then it was assessed as defensible to cease the prescription.

In the preceding examples, we have seen the doctors present the sensibility of a case by invoking its status as a representative of some larger class of cases. This typicality was accomplished by such efforts as drawing an analogy, telling a folk-tale, generalizing to the population at large, and referring to socio-economic class. It is interesting to note the contrast between the use made of the general case here and its use in the preceding chapter. There we saw that one of the procedures doctors employed in arriving at a diagnosis was to cite the general case and then work to articulate it with the particular case. When they come to provide warrant for their decisions, they display the
particular case as an instance of the general case. (This movement from
the particular to the general was remarked upon specifically in the
excerpts from Dr. Henry and from Dr. Dudley.)

The set of examples also contained illustrations of the use of
likelihood as warrantable grounds for action. The doctors evinced a
concern to depict their behavior as having been formulated in light of
a due regard for the possible occurrence of some specified outcome. As
we saw, there were times when playing the odds was counted as sanction-
able. At other times, playing it safe was the decided course.

The doctors sought to establish their behavior as comparable
with their behavior of the past. This comparability was accomplished
by depicting a current course of action as in line with a policy they
follow regularly and routinely. This method was not the only one used.
In interviews not included here as examples, doctors established com-
parability simply by citing a particular previous situation in which
they followed the same course as their current one.

Action was counted as warranted by treating certain described
conditions as causal agents. We saw that situational constraints of
limited time and of record-keeping procedures were used in this way.
But such considerations as the "inevitable" course of a given disease
or the "uninformative" answers of a given patient were also cited by
the doctors as forcing them to act as they did.

In order to recommend the reasoned nature of their behavior,
the doctors pointed to the instrumental efficacy of their course of
action. They spoke of the good it accomplished or the harm it prevented.
What was counted as good or harm was specified with regard to the
particular case at hand.

Finally, the doctors warranted their behavior on the grounds of a natural or moral order. The statements "it's not fair" or "it's his prerogative" signalled this practice in the examples presented above. Other interviews contained such statements as "you don't want to tell a patient he's going downhill" and "A patient shouldn't have to pay for one mistake all his life." As mentioned earlier, once the grounds of moral requiredness are invoked, a given action is regarded as necessary regardless of how it might be assessed from the standpoint of the other five perceivedly normal values.

We turn now to the interviews with the patients. Their method of assigning warrant is the same as that of the doctors. They provide warrant for their assessments of the doctor's competence by assigning the values of typicality, likelihood, comparability, causal texture, technical efficacy, and moral requiredness.

The first example presents Mr. Shore's estimation of his experience with Dr. Warren:

**TECHNICAL EFFICACY**

Pt: He is a good doctor. He understands, I know that. And uh well like me, I been having like, well you heard him, I've been having alot of trouble, and uh well he understands all my troubles, I know that. And uh, he's a pretty good doctor. He's doing his best. It's just

**TYPICALITY**

like any other doctor, 'cause I had uh, I had uh one of

**COMPARABILITY**

these private doctors and it's, it's the same thing. Uh, same medication uh this other doctor give me, well, he's, he's giving me. So it don't make any difference.

Mr. Shore has offered his appraisal of Dr. Warren as a "good doctor" on
three grounds. First, he effectively carries out the task of understand-
ing the patient's "troubles." Second, he is typical of doctors in general. Third, Mr. Shore ties his experience with Dr. Warren to a past situation by describing the medicine he received from Dr. Warren as the same as that from another doctor.

The next example is from the interview with Mr. Vance. His doctor, Dr. Compton, has told him that his income is too high for him to be eligible for continued treatment at the clinic. In commenting upon this state of affairs, he said:

Pt: I know I won't, I won't be no regular, 'cause, you

CAUSAL TEXTURE
see, I makes a little too much money for them to con-
tinue seeing me.

I: How do you feel about that?

Pt: Well, (laugh) there ain't nothing, there ain't

LIKELIHOOD
nothing I can say I don't guess about that there,

CAUSAL TEXTURE
just when you make more money than this big doctors' systems allows, well, then I'll just have to go along

LIKELIHOOD
with it I guess, least I see that's the only thing.

Citing his financial status as the causative condition, Mr. Vance has accounted for the doctor's not taking him as a patient. He assessed it as unlikely that he could say or do anything "about that there." And so, setting his own situation up against the rules of the system, he described these circumstances as constraining his own decision to "go along with it."

The third example is taken from the interview with Ms. Flowers
concerning her appraisal of Dr. Ferguson:

Pt: Mmm, well now its, course like, well I just, my personal feeling you know about how he is, I think he's a very

TYPICALITY
good doctor. . . . And uh he's not, you know, the type to be, you know, ornery. . . . You know, he seemed to me like, like he evidently with, you know in there he's

CAUSAL TEXTURE
concerned 'cause when he looked in my chart and saw that I hadn't lost any weight, well he, you know, he told me I'm gonna have to do something, that, so I think he's a real good, you know, good doctor. . . . I trust my

LIKELIHOOD
doctor and I think he, you know, would do what he feel is best for me, that's, because, you know, if I didn't uh feel that he would, you know, if he didn't

TECHNICAL EFFICACY
give me the right, you know, treatment, I wouldn't come to him. (She laughs.)

Ms. Flowers expressed her judgment of Dr. Ferguson by drawing on the notion of typicality. He was classified as the type of doctor who is not "ornery." She saw his advice to her "to do something" as caused by his concern over her weight. Her trust in him is described as warranted on the grounds that he likely would act in her best interests. Furthermore, if his treatments were not efficacious, she would not even "come to him."

In the final example, Ms. Vaughn is presenting her assessment of Dr. Henry:

Pt: Dr. Henry to me, Dr. Henry is real good you know? He,

MORAL REQUIREDNESS
he dews his duty, he takes his time and he dews it right, and that's Dr. Henry. He dews it right. (She laughs.) And, uh, with the ones I've seen, really, I haven't seen
COMPARABILITY
any here that wasn't good. My children saw the eye
doctor here recently and right onto them, they seem
to be all good. And, uh, I was havin' this, uh, pain
from this nervous stomach and this new medicine that

TECHNICAL EFFICACY
he put me on seem to help because my pain is so severe
sometimes until it helps. It really do.

According to Ms. Vaughn, Dr. Henry can justifiably be described a good
doctor because he correctly performs his moral obligation. Also, she
has tied her assessment of his competence to similar assessments with
regard to her experiences of the other doctors in the clinic. Finally,
her appraisal is warranted on the grounds of the efficacy of his pre-
scribed medicine in relieving her pain. And as she added to me later,
"When your pain go away, I mean, it's no more you want."

The preceding excerpts have shown the patients establishing the
competent i.e. truthful character of their encounters with the doctors
by invoking the value of typicality. That is, one of the ways they
provided warrant for a doctor's behavior was by describing it as "just
like any other doctor's." They also assessed their encounters on the
basis of what they might likely expect from a doctor. Third, they as-
signed warrant by finding their current treatment comparable to that in
their past. Fourth, they delineated certain conditions as causal
phenomena. In the examples above, we saw procedural rules of the hos-
pital district used in this way. Further, warrant was assigned on the
basis of the effectiveness of the doctor's treatment in relieving their
illness. And sixth, the doctors' actions were judged accountable with
respect to their conformity to such moral obligations as "doing his
duty."
The findings of this chapter, then, are that doctors and patients alike established warrant for the competent and successful nature of their encounter by assigning to the transactions of that encounter the values of typicality, likelihood, comparability, causal texture, technical efficacy, and moral requiredness. These findings substantially support those reported by Garfinkel (1967:93-94). Garfinkel set up an experimental situation in which subjects were asked to report as they proceeded, the sense they were making of answers to their questions. The experimenter told the subjects that their questions were being answered by a psychotherapist. What he did not tell them was that the answers were being given at random. That is, the questions had to be asked in such a form that they could be answered by yes or no. The "psychotherapist" replied with a yes or no on an entirely random basis. Garfinkel found that the subjects worked to justify the status of the answers as reasonable and sanctionable advice through the use of the six values we have been discussing. In his words,

The subject's task of deciding whether or not what the adviser advised was "true" was identical with the task of assigning to what the adviser proposed its perceivedly normal values (1967:94).

McHugh (1968) replicated Garfinkel's experiment, treating the perceivedly normal values as constituting relativity, one parameter of the definition of the situation. As he explains, "Relativity is an activity of studied reckoning . . ." (1968:113). On the basis of the analysis of his data, McHugh proposes that his subjects engaged in this "studied reckoning" primarily during times when their assumptions about the nature of the interaction to which they were party started to falter.
That is, the occurrence of contradictions and discrepancies that challenged and disrupted their original definition of the relationship between them and the experimenter made it necessary for them to attend to the concerted work of assessment. The subjects then consulted the components of relativity and decided whether or not an attribution was typical, likely, causally textured, and so on.

In both of these experiments, the subjects were seen to establish the good sense of the situation by making it out to be in accord with the perceivedly normal values. What the data in the present study has shown is that this manner of assigning warrant appears also in a more routine setting. Though it is true that doctors and patients do not face questioning by a sociologist after every session, they do, as we mentioned earlier, have repeated occasions on which they must make the kind of assessments they made to me. And when they came to give their appraisals, they did so by invoking the same grounds found as warrantable in the experimental settings.

Two implications can be pointed up on the basis of these findings. First, it is not necessary to put persons in a specifically senseless setting in order to make visible their methods of assessment. It is not even necessary that they be in a situation where what definition there is, is cast into doubt. The methods are not so unavailable or unconstant as such experimental procedures suggest. And second, we have given some empirical evidence in support of the theoretical proposal of the other two investigators that the assigning of perceivedly normal values in establishing warrant is the way persons in general classify and evaluate their environment.
CHAPTER SEVEN

CONCLUSION

In the opening chapter, the crucial place of the interaction between the doctor and patient in the therapeutic undertaking was indicated. Its significance was seen to reside in the fact that here symptoms are discovered, diagnoses formulated, cooperation elicited, and treatment begun. Yet, despite the stress that the body of published research lays on the importance of satisfactory communication and the problems it has outlined as arising from unsatisfactory communication, the workings of the communicative process itself have rarely been investigated. Even those authors who have taken as their focus the actual verbatim exchanges between the doctor and patient have done their analyses on the basis of coding categories that leave out of account the imputations and intentions of the participants and therefore have not moved us further in the direction of understanding the communicative process.

The argument was made that the underlying theoretical perspective guiding previous research is responsible for many of the gaps in our knowledge about the interaction between doctor and patient. That perspective attempts to explain face-to-face interaction using as its major conceptual apparatus the notion of status and its concomitant role-expectations. That is, the acting member of society is treated as a function of his position and its requirements. For him to be seen as
competent, he must perform his interactions and other undertakings in accordance with the ideals of conduct attached to his particular status.

The difficulty with this conception lies in its inattention to the fundamental issue of the ways in which the actor orders and assigns meaning to events in his environment. What is omitted is any discussion of how the actor recognizes status and role-expectations over the course of a developing interaction, how he matches the general ideas of conduct with the particulars of a concrete situation, how he knows when a given sequence of behavior is in line with a given status, or how he manages the unpredictable contingencies arising in the midst of interaction which are not covered by even the most detailed prescriptions and pro-
scriptions attached to a status. As Cicourel (1970b) points out, inso-
far as a theory of interaction neglects these interpretive and evalu-
ative efforts on the part of the actor, then it lacks the very element that would allow it to work. What this shortcoming has meant with re-
gard to investigations of the interaction between doctor and patient is that the manner in which the doctor and patient understand one another, the judgmental work entailed in formulating a diagnosis, and the orient-
ing values operative in assessing the warrantable character of the encounter were yet to be addressed.

In light of these considerations, ethnomethodology was proposed as an alternative theoretical perspective. According to this view, interaction is regarded as essentially an interpretive process during which meaning is continually worked out by the participants. Within this perspective, events are not treated as having meaning independent of the processes whereby the actor provides them with meaning. That is
to say, the systematic, organized property of activities is not inherent in the activities but is accomplished through the actor's formulations which establish the meaning of potentially equivocal events. The potentially equivocal character of events necessitates continual interpretation on the part of the actor. Therefore, the interpretive work itself is taken up as the topic of study and is made available as such through the actors' accounts. These accounts are examined not so much for their content as for their constituent features.

On the basis of the perspective provided by ethnomethodology, a study of the interaction between doctor and patient was designed with the purpose of elucidating issues involved with understanding, diagnosis, and warrantability. The neighborhood public health clinics operating under the aegis of the Harris County Hospital District of Texas were chosen as the site for the project. Methods included a period of observing the facilities and daily routines of each clinic, tape-recording a consultation between each doctor and two of his patients, and interviewing each participant regarding the specifics of their interaction. In Chapter Two, the practical circumstances surrounding the accomplishment of the project were detailed. The discussion dealt with troubles in gaining initial permissions, with the negotiated character of interviewing, with the documentary work entailed in sociological inquiry, and with the attitudes of the participants towards the project.

Chapter Three described ethnographic details of each clinic as well as the attitudes towards and impressions of the clinics reported by the patients and doctors involved in the study. This discussion stressed the point that the sense of the proceedings is provided by the
observer and will be different depending upon whether that observer is a visiting sociologist, a member of the clinic's staff, a doctor, or a patient. The difference stems not only from personal idiosyncracies but also from the nature of the involvement in the proceedings.

The presentation in the fourth chapter addressed the issue of common understanding. Sequences from the conversations between the doctor and patient were given along with the participants' later elaboration on these sequences. The argument was made that common understanding does not reside in aggregate amounts of shared agreement on substantive matters. Such overlap could not be consistently found, even though the interaction proceeded without evident disruption and the participants reported they had understood each other. It was proposed that common understanding resides in the sense of shared agreement, a sense maintained by the participants' assumption that sensible talk was being uttered and by their efforts to establish this sense through embedding the talk in a personally constructed context. This assumption and this work were demonstrated as operative even when discrepant versions of an event became apparent to the doctor or patient. The capacity to maintain the sense of shared agreement was seen to be grounded in the use of the interpretive procedures delineated by Cicourel. At the close of the chapter, the ethnographically presented data was re-cast along the lines of these interpretive procedures.

The process of constructing a context was examined further in Chapter Five in relation to the task of diagnosis. The doctors' use of the documentary method constituted the nature of the interpretive work required to accomplish this task. What a given symptom might signify
had to be formulated by the doctor through the construction of an underlying context or pattern that the symptom could be seen as representing. The doctor consulted his background knowledge of the patient, typifications regarding patients, and his store of medical learning as guidelines by which to shape the underlying pattern. The inner dialectic of the documentary method is such that the specified symptoms, the guiding constructs, and the elaborated context mutually determine one another in that the underlying pattern is known only through the appearances it is used to interpret. Procedures involved in making this articulation comprised a set of ad hoc practices which enables the doctor to bring general considerations to bear on specific circumstances.

Chapter Six investigated the way in which doctors and patients endowed their joint undertaking with its rational, sensible properties. Statements from the doctors and patients were examined in order to determine the grounds they cited in establishing warrant for their judgments and actions. These grounds were designated as the perceived normal values. That is, doctors and patients assessed their encounter and the action derived from it on the basis of typicality, likelihood, causal texture, comparability, technical efficacy, and moral requiredness.

The focus of this study of the interaction between doctor and patient has been on the interpretive work involved in finding the sense of the conversation, in formulating a diagnosis, and in deciding the competent nature of the enterprise. The participants were shown to have accomplished these tasks through the use of a set of interpretive procedures, the documentary method, and the perceivedly normal values. As
was pointed out in previous chapters, these elements of the interpretive process have already been delineated, primarily in the writings of Cicourel and of Garfinkel, and proposed as invariant constitutive features of all efforts to establish the sensible and rational character of social action. The aim of the present study has been to describe ethnographically the workings of the interpretive process and how its constituent elements look on the occasion of their use in the specific situation of a patient's consultation with his doctor. Garfinkel (1967) stressed the necessity of such investigations in the interest of discerning the peculiar stamp of the phenomenon in various settings.

The elements of the interpretive process have been treated as theoretically separate for purposes of analysis and exposition. But empirically, they fold into and depend upon one another and form a single set of practices through which the doctor and patient and all others involved in managing practical action assign meaning to events in their environment. In a paper by Kenneth Leiter (1974), the connection between these practices is elucidated. Leiter grounds his presentation on evidence from two sources. First, he examined data he had gathered on the practices utilized by teachers in assessing the level of their students' ability and performance. Second, he examined the textual materials of Cicourel and Garfinkel. On the basis of his investigations, he shows that the documentary method relies on the use of the interpretive procedures. Since Garfinkel proposes that the perceivedly normal values are managed through the work of the documentary method, then this element of the interpretive process also is argued by Leiter to rely on the use of the interpretive procedures.
In conclusion, two points will be made with regard to the previously mentioned assertion that the elements of the interpretive process are invariant features of any attempt to establish the sensible and rational character of social action. That is to say, any practical undertaking will require the use of the interpretive process. The first implication of this assertion has to do with the doctor's endeavor to communicate with his patient and to establish a diagnosis. Since this task is an eminently practical one, there is no way to rid it of interpretive work. The effort to do so has arisen from a general attitude of denigrating common sense reasoning—the domain of the interpretive process—in comparison with scientific reasoning and has taken two paradoxical directions. On the one hand, recommendations have been put forth to make the language of the consultation less scientific. On the other hand, recommendations have been put forth to make the diagnostic procedure more scientific. Both are aimed at reducing the necessity of interpretive work and thereby reducing the chance of error. Each of these proposals will be dealt with in turn.

The notion that substituting plain language for technical jargon during the consultation would obviate the necessity for interpretation was discussed in Chapter Four. According to this view, the use of scientific terms results in misunderstanding or in total bafflement on the part of the patient. Plain language is thought to carry obvious meaning, therefore requiring no interpretive work which might give rise to deviant definitions.

As was demonstrated in that earlier chapter, however, everyday talk is replete with expressions whose specific sense must be derived
through embedding them in a context. This context is constructed separately by each participant according to his own set of relevances. As Kellner points out, "... an equivalent language disposition and usage by two or more individuals does not furnish them automatically with a mutual understanding of their given context" (1970:84). The degree of overlap between participants' constructions is never more than approximate. One might go so far as to suggest that it is the very vagueness of plain language that allows a sense of shared agreement to be preserved. For, with horizons of meaning so open, radical discrepancies and irreparable disruptions rarely surface. In any case, the point is that no amount of mending will fix up the language in such a way as to eliminate interpretive work on the occasions of its use.

Recommendations aimed at eliminating interpretive work from diagnostic procedures will also meet with failure. Horvath (1964) and Scheff (1963) have both made such recommendations. Noting that the problem of uncertainty in diagnosis resides in the overlap of well persons and sick persons with respect to the criteria used in diagnosis, these authors are concerned that various biases on the part of the physician affect his decision as to where to draw the line between the two populations. These biases include not only the doctor's personal inclinations towards treatment versus nontreatment as a general policy, but also his attitudes toward any particular patient.

Horvath suggests a search for more refined tests that will eliminate false positives and false negatives and thereby eliminate the effect of bias in diagnosis. Should such tests not be forth coming, he suggests that
. . . careful studies will be necessary to evaluate the cost to the system of having various combinations of false positives and false negatives. Eventually it should be possible to minimize this cost by setting specific measurable criteria to which the diagnostician must adhere (1964:339).

The data in the present study have shown that the doctor's interpretive work is required from the very beginning in arriving at enough sense of his patient's illness to know what tests to order. Horvath's plan cannot bypass this step. Moreover, given even the most elaborated and sophisticated "measurable criteria," the doctors would still have to match these criteria against a specific case and that effort requires the kind of ad hocing practices (i.e. interpretive work) discussed in Chapter Five.

Scheff too wants to move as far away as possible from relying on the " . . . perhaps refined, but nevertheless obscure, judgment processes of the physician" (1963:105). To this end he offers a mathematical equation as a way to decide statistically the value of treatment versus nontreatment in a given case. But the numbers that constitute his equation themselves are based on judgments. They are derived from judgments made by a group of doctors about which particular people have been afflicted with a given disease, about the method of treatment leading to a cure, and about the length of time involved in that cure. The numbers are also derived from judgments made by personnel in the life insurance companies about the various degrees of disability incurred by a given disease and about the costs associated with each degree of disability. Furthermore, the equation leaves out altogether certain key considerations:
... this approach does not include everything which physicians weigh in reaching decisions (pain and suffering cannot be weighed in this framework). ... (1963:105).

I am not arguing that the suggestion by Scheff, or the one by Horvath, might not aid the doctors in the accomplishment of their task. Rather, I am arguing that the results of the suggested diagnostic procedures will become one more factor among the many the doctor uses to orient himself to a given patient and that his (or somebody's) interpretive work is required before, during, and after the use of such procedures.

The other implication to be drawn from the assertion that any practical undertaking requires the use of the interpretive elements described in this study regards the study itself. That is, someone could write a dissertation on the use of the documentary method, interpretive procedures, ad hocing practices, perceivedly normal values, contextual embedding and so on employed in the construction of this dissertation. For, so long as the sociologist wishes to treat the features of action that make it a sociological event rather than a physical or biological one, then he, like the participants of this study, must engage in interpretive work.¹ The difference resides in the matter of practical tasks and interests. Whereas the participants' interpretive work was oriented to accomplishing the tasks that fell to them as doctors and patients, mine was directed to an investigation of their interpretive work itself.
NOTES

Chapter One. Introduction

1. This summary is based on one given by Wilson (1970:59-61).

2. Quotation marks are applied because the word is used metaphorically. The term "assign" implies the correspondence theory of reality, a theory which conceives of a duality between the concrete and the perceived object. Ethnomethodology subscribes to a congruence theory of reality wherein the object is seen as constituted in and through the act of perceiving and no duality is postulated.

Chapter Two. Methods

1. An extensive discussion of these considerations is found in Douglas (1970:22-44).

2. The names of all the clinics are fictitious.

3. This name and all succeeding names of doctors, patients, and personnel of the clinics are fictitious.

4. This sixth feature of sociological inquiry as I have stated it, is a combination of Garfinkel's sixth and seventh features. So the one I have designated as number 7 corresponds to his number 8.

Chapter Three. The Setting

1. Of course, even this depiction of the layout, available personnel, and general services at the clinics did not spring "pure" from the setting to the page. It is a conglomerate picture made
from the information given by the staff and by my own observation. With this comment in mind, I will give the preliminary description as a base-line against which to view the various senses of the clinics provided by the doctors, patients, staff, and myself.

2. It is instructive to view these statements by Dr. Hunter in light of Zimmerman's notions of the practicalities of using rules (1970). That is, the competent use of some formally prescribed procedure is a matter "... not of compliance or deviance but of judgmental work providing for the reasonableness of viewing particular actions as essentially satisfying the provisions of the rule, even though the action may contrast with invocable precedent..." (1970:237-38). If the essence of the policies prescribed by HEW is seen to be providing for the optimal care of the patients, then Dr. Hunter, relying on his judgment and experience, must manage to apply the rules in such a way as to accomplish this outcome. Thus, a competent use of the rule restricting the administration of antibiotics may entail administering the antibiotics in an unrestricted manner in some cases (e.g., diarrhea) in order to ensure the successful outcome of the goal of the rule—i.e. optimal care of the patient.

Chapter Four. The Nature of Common Understanding

1. Garfinkel discusses this feature of understanding in the second chapter of his Studies in Ethnomethodology (1967).
2. I am indebted to Dr. Steven Tyler for this point.

3. Cicourel has formulated his discussion in several ways.
   My adaptation draws on facets from each of those discussions
   but primarily follows the listing in his "Basic and Normative
   Rules in the Negotiation of Status and Role."

Chapter Five. Formulation of a Diagnosis

1. For the sake of brevity, I have excluded from the printed con-
   versation such material as the details of the doctor's instruc-
   tions to the patient and their discussion of dates for appoint-
   ments. Phrases that might reveal the identity of the patient
   have also been excluded.

2. The fact that these practices are found in the doctors' work
   not only substantiates Garfinkel's findings but also makes it
   clear that an experimental situation is not required in order
   to render observable the practices of the documentary method.
   These are available in the routine work of the members.

3. This finding concerning the heterogeneous and situation-specific
   character of background knowledge substantiates the similar
   finding by Leiter (1973) concerning background knowledge used
   by teachers to interpret test scores.

Chapter Six. Making the Encounter Rationally Accountable

1. Garfinkel speaks of the perceivedly normal values as being as-
   signed and then regards it as more appropriate to speak of
   their being managed. They are managed through the work of the
   documentary method. Since the features of this method were
detailed in the last chapter, that discussion will not be repeated here. My use of the word "assign," then, is meant to be a metaphorical use.

2. In Chapter Eight of his Studies in Ethnomethodology (1967), Garfinkel distinguishes between the rationalities characteristic of everyday life versus those characteristic of scientific theorizing. In Chapter Two, he reports the disruptions that arise when the scientific rationalities are applied in scenes of social interaction.

3. McHugh (1968) describes his conceptualization as an adaptation of Garfinkel's in that his schema excludes one of Garfinkel's components and adds one not included by Garfinkel.

Chapter Seven. Conclusion

1. Garfinkel (1967) and Winch (1958) stress this point.
APPENDIX A

CONSENT FORM

Would you help us in a study about how doctors and patients talk to each other? We would like to make a recording of your conversation with your doctor and then have a short talk with you about it.

We want to protect your privacy. We will not use your name on any of our records and we will erase the tape recordings as soon as we’ve taken the necessary information from them.

If you find that having your conversation recorded bothers you, we will stop immediately.

We hope that this study will benefit the doctors in practice and medical students in training.

Please ask any questions you have.

_________________________________________
Participant

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APPENDIX B

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Residency Requirement: In order to be eligible to receive services at the clinics, a patient must have lived six consecutive months in Harris County.
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