Frame negotiation in doctor–elderly patient consultations

Justine Coupland
UNIVERSITY OF WALES COLLEGE OF CARDIFF

Jeffrey D. Robinson
UNIVERSITY OF CALIFORNIA AT LOS ANGELES

and Nikolas Coupland
UNIVERSITY OF WALES COLLEGE OF CARDIFF

ABSTRACT. Institutional discourse typically involves a dialectic between institutional (e.g. medical) frames and socio-relational frames for talk. The paper draws on audio-recorded data from a geriatric outpatients clinic in the UK to show how doctors and elderly patients collaborate in and negotiate the work of entering an apparently medical frame of talk. Particular attention is paid to sequences involving how are you?-type elicitations. Social and medical framings of talk are established and blended in complex discourse patterns. This blending may have a special salience in contexts, such as geriatrics, where holistic care has an explicit priority.

KEY WORDS: conversational openings, frame analysis, geriatric medicine, medical discourse, phatic communion

1. INTRODUCTION

Investigations of doctor–patient interaction have followed a relatively limited agenda. Asymmetry has been a dominant concern. Before the 1980s some researchers were attracted by the claim that a ‘need for asymmetry’ governed the practice of medicine (West, personal communication). Since then, research has been more concerned to explore whether abstract formulations of medical interaction, such as ‘asymmetry’, are matched in practice. In many instances, doctors have been found to dominate their patients—for example, by assuming and asserting rights over the management of turns and topics, or by speaking from a more technical, and so apparently a superior, knowledge-base (see Drew and Heritage, 1992, for a recent overview). Doctors’ talk has also been shown to operate within a bio-medical ‘frame’ (in the general sense of Goffman, 1974),
reflecting the institutional position from which they conventionally speak and, again, the priorities they appear to impose on their patients during consultations. This has been contrasted with a socio-relational frame within which a broader agenda of issues, and indeed broader definitions of health and health-care, might be established (Fisher, 1991; Mishler, 1984). For Fisher, the framing of medical discourse is a moral, ideological and gendered issue which relates directly to the quality of the medical enterprise itself.

Some important qualifications need to be added, however, to the claim that asymmetry is constant throughout medical interactions (cf. Drew and Heritage, 1992; Linell and Luckman, 1991; Maynard, 1991; ten Have, 1991). There is no shortage of descriptive evidence demonstrating discursive asymmetry. But it appears that the literature may have made simplistic assumptions about the ‘normality’ of symmetrical discourse and about the problem-status of asymmetrical discourse features. As Linell and Luckman argue, asymmetries exist in many contexts of talk, outside as well as inside institutions. Also, West and Frankel (1991) show how at least some patients are well disposed to the controlling behaviours of their doctors and derive support from their perceived authority and status. To raise these issues is not to doubt that genuine moral and relationship problems in medical interactions attach to discourse asymmetry; they clearly do. But equally clearly, we need to build more differentiated accounts of the specific contexts of medical interaction and of the wide range of implications that interactional configurations can hold for patients and doctors alike. Asymmetry needs to be viewed as a variable and interactionally achieved dimension of medical interaction (Frankel, 1984; Maynard, 1988; ten Have, 1991), and not as a discursive index of the inherent inadequacy of health-care delivery.

The same applies for related analyses in the framing of medical consultations, which is our main concern in this paper. The ‘medical versus social’ dichotomy is, in fact, difficult to establish as an absolute distinction in medical discourse, not least because all talk, indeed all utterances, articulate socio-relational meanings which interact with and qualify ideational meanings (J. Coupland et al., 1992; Holmes, 1990; Tracy and Coupland, 1990). Even when a ‘medical’ frame apparently dominates in a specific medical encounter, participants will presumably pursue socio-relational goals in certain dimensions of their talk and these may be more visibly foregrounded at particular junctures, such as during opening and closing sequences. Not all talk within the doctor–patient consultation is necessarily salient to participants as ‘medical talk’. Also, apparently ‘socio-relational talk’ may well contribute to the ‘medical’ goals of (one or more) participants. An attempt to capture how discourse events and their meanings are variably framed by and for participants will need to be sensitive to these contextual considerations.

In this spirit, this paper gives an analysis of how the opening phases of consultations between doctors and elderly patients are achieved, focusing on how interactants collaborate in and negotiate the work of entering an
apparently medical frame of talk. In particular, we give an account of sequences involving the range of how are you?-type elicitations made by doctors in a corpus of 85 audio-recorded consultations. We shall highlight some of the uncertainties and ambiguities that are involved in frame negotiations, and which participants themselves need to deal with.

The relevance of examining specifically geriatric medical data is that social frameworks have an acknowledged salience in the medical care of elderly people. Geriatric medicine is often associated with an ideology of holistic medicine (Pathy, 1991; see also J. Coupland and Coupland, in press; N. Coupland, in press) and the holistic ideal is to recognize the social and relational frameworks within which bio-medical problems occur. It is to be expected that, in geriatric consultations, doctors' and patients' priorities for talk will foreground relational concerns in ways that have not been apparent in the 'mainstream' doctor–patient literature. At the same time, older people are scarcely a minority group as users of medical services, and it is altogether appropriate for studies of medical interaction to represent older populations, in fact within the main stream of research.1

We begin by elaborating on our initial comments about asymmetry and framing in doctor–patient consultations, going on to argue that the notion of 'phatic communion' can add some insight to analyses of consultation openings and frame negotiation processes.

2. ASYMMETRY AND THE FRAMING OF DOCTOR–PATIENT INTERACTION

Ten Have notes that 'most researchers who have studied doctor–patient interaction in detail have given their primary attention to questioning sequences and consider the doctor's handling of these sequences as their primary instrument of interactional control' (1991: 145). It is not simply that doctors ask more questions than patients (Frankel, 1990; Todd, 1984; West, 1984: 71–96), but that (1) question-asking is dispreferred when done by patients (Frankel, 1983, 1990; West, 1983); (2) the question structure is often restrictive, allowing for only short, factual answers (Frankel, 1984; 1990; Mishler, 1984: 59–91; West, 1984: 82–8); (3) question sequences often come in three-part structures, allowing the doctor to initiate the topic-question, hear the patient’s answer, and maintain control of the floor with a third-position 'assessment' (Frankel, 1984, 1990; Mishler, 1984: 59–91; Todd, 1984); (4) third-position 'assessments', such as uh-huh, mm-hm and right, do not clearly signal to patients the force of doctors' evaluations, but simply act as conversational continuers (Atkinson, 1982; Frankel, 1984); and (5) doctors rarely give accounts for asking particular questions and shifting topics (Mishler, 1984: 95–121), which leads to the attribution that doctors under-disclose and over-control. Interactional asymmetry has been held to be matched by (and presumably to be dictated by) a perspectival asymmetry. The dominant clinical approach has been said to follow a reductionist, bio-scientific model, viewing health as a predominantly biological phenomenon, symptoms being interpreted in terms of physical
pathology (McWhinney, 1989; Mishler, 1984). In many cases, on the other hand, patients themselves will view health and illness as an intimately personal phenomenon with both psychological and social implications for themselves as individuals, for their relationships and for many other aspects of their social lives (Todd, 1989).

In these ways, discourse analytic research has documented patients as depowered, in that they both marshal (typically) fewer interactional resources and operate in a (potentially) alien ideological climate. Constraints are imposed on the flow of personal and psycho-social information which can be important not only to the patient but also to the doctor for diagnosis and treatment (Fisher, 1991; Frankel, 1984; Larsson et al., 1987; Mishler, 1984; Sankar, 1986; Todd, 1984, 1989). With much research focusing on doctors’ questioning sequences, found primarily in the diagnostic episodes of consultations, little attention (although see ten Have, 1991) has been paid to other episodes, and especially the margins of interaction.

Some studies have shown that doctors and other professionals do not speak exclusively in ‘the voice of medicine’ or in their institutionally given roles, nor do patients exclusively speak in the ‘voice of the lifeworld’ or act in the role of patients. Establishing ‘social’ or ‘medical’ discursive frames is at least potentially a multilateral design task. Also, frame management can itself be functional in terms of fulfilling higher-order interactional goals. Ragan’s (1990) analysis of verbal play in the gynaecological exam demonstrates how a nurse practitioner’s strategy of moving out of medical talk into socio-relational talk in the middle of an intrusive physical examination can mitigate the inherent threat of the medical procedures—the social in the service of the medical. The existence of multiple task and social goals in interaction is well documented (Craig et al., 1986; O’Keefe and Shepherd, 1987; Tracy, 1984; Tracy and Coupland, 1990; Tracy and Moran, 1983). In medical encounters generally we need to be aware of how interactants achieve a blending of diverse priorities, and it is precisely this management of relational and medical frames of talk that our study addresses.

3. PHATIC COMMUNION

Malinowski coined the term ‘phatic communion’ to identify ‘a type of speech in which ties of union are created by a mere exchange of words’ (1923: 151), and the notion has been invoked and redefined in many places since 1923 (see J. Coupland et al., 1992, for a review and reinterpretation). We take phatic communion, or phatically designed talk, to combine two essential functional characteristics: the relative foregrounding of socio-relational goals over informational and task goals, and a relative lowering of commitment to openness, factuality and the ideational significance of utterances. In this way, ritualized exchanges such as greetings and some forms of ‘smalltalk’ are designed phatically. Their ideational significance is
conventionally downgraded, although they are crucial elements of the management of routine social encounters. As Malinowski argued, speech is the ‘intimate correlate’ of the need for communion among humans, evident in the phatic expression of ‘mere sociabilities’. Even though, for Malinowski, phatic communion is dislocated from ‘practical’ or ‘purposive’ action, he saw it as highly functional, for example in defusing the threat of taciturnity in social encounters.

Even our most instrumental, transactional encounters, including medical consultations, involve far more than the transmission and reception of factual (e.g. diagnostic or prescriptive) information (cf. West, 1984). Laver (1974) notes that, as interactors move from opening sequences of talk to the ‘business at hand’, phatic communion serves a propitiatory function, defusing the possibly hostile attributions of silence; it serves an exploratory function, helping interactants form a working consensus (cf. Goffman, 1959); and it serves an initiatory function of getting an interaction under way. During the opening sequences of doctor-patient talk, then, we might expect there to be some role for phatically designed talk which would function, at least minimally, as a transitional mode, bridging into more (medical) troubles-oriented exchanges. As Sacks (1975) notes, such a transition will often mean traversing social environments, requiring a shift from ‘relational’ categories to ‘professional’ categories, or footings (in Goffman’s [1981] sense).

In an earlier study (J. Coupland et al., 1992), we interviewed 40 elderly members of a (UK) day centre about their experiences of health-care. In particular, we examined their responses to how are you? when it was the scripted first question of each interview. We found extreme variation in the interviewees’ responses, spanning formulaic, blandly positive self-appraisals (for example, alright thank you; and oh I’m fine thank you) to uncontroversially negative and intimate disclosures of ill-health, frailty and depression (for example, well I’ve got everything wrong with me (. ) my legs yeah everywhere even my fingers; and erm (. ) I got (. ) rheumatoid arth (. ) arthritis is in my legs and they’re terrible painful). We then isolated the range of strategies whereby elderly interviewees would hedge or mitigate the full negativity of their more disclosive responses to how are you? What we termed ‘good news, bad news’ formats were common, counterbalancing more positive and more negative self-appraisals within single utterances or over adjacent utterances. For example,

I’m alright (. ) I do suffer with my nerves though I get injections every month (. ) but I (. ) I’m going on fine

and

not too bad (. ) I had a bad day er Saturday (. ) arthritis arth arthritis in my knee (. ) I don’t know I only went down the street to get some food for Sunday and (. ) I had a job to get back home but it’s better today

The findings of this interview study alerted us to the importance of frame negotiations in naturally occurring medical encounters. Specific considerations were that (a) responses to how are you? in the interview setting were
inherently variable; and that (b) accounts of health problems regularly showed sensitivity to relational concerns (i.e. interviewees used hedging devices and showed an apparent preference for non-negativity in their responses). We wanted to explore the contention that a rather broad class of *how are you?*-type elicitations in medical consultations will be an element of even more complex processes of frame negotiation, where doctors and patients blend their socio-relational and bio-medical priorities.

At the same time, we need to be sensitive to the likelihood that even wholly relationally focused exchanges can themselves be medically significant. (For example, a patient’s preparedness to engage in ritualized ‘smalltalk’ early on in a medical encounter might be diagnostic of relatively good morale.) This implies that ‘smalltalk’ is very probably an inappropriate gloss. More importantly, we should recognize that ‘the (medical) business at hand’ in a geriatric context might itself include the exchange of personal, social data and personal accounts of the sorts we take to be ‘smalltalk’ in other transactional settings. That is, analyses of the framing of geriatric medical settings may take us close to the ideological heart of the geriatric enterprise.

4. THE DATA CONTEXT

The data for this study were collected at a geriatric outpatients clinic at a major hospital in South Wales. The study was designed on ethnographic lines, to involve multiple intersecting levels of analysis, centring on audio- and some video-recording of interactions between staff and patients during clinic hours, but supplemented with open-ended interviewing of all participants. The data reported here derive from participant observations and audio-recordings of the doctor–patient consultations themselves. The complete consultation corpus comprises 102 interactions, involving eight doctors (six male and two female) ranging in status from junior housemen through registrars and consultants to very senior staff. For the frame negotiation analysis we concentrate on 85 of the consultations, those whose opening exchanges were clearly audible because they occurred close to a fixed-position microphone. Patients’ ages (in the whole corpus) ranged from 62 to 97. All patients attending the clinic are over 60, although elderly patients with single, specific medical conditions are often referred to other specialized hospital clinics. So, the presentation of complex and multiple ailments is characteristic of patients called to the clinic we observed. There is a predictable predominance of more or less routine age-related medical conditions represented, from minor to acute. Many patients are attending the clinic on one of a series of occasions, for example being under observation pre- or post-hospitalization.

Participating doctors agreed to have a micro-recorder running on their desk and a researcher present during the entire consultation. The researcher-observer sat in full view of doctor and patient, but towards the back of the consulting room; s/he made written notes of contextual infor-
mation and non-verbal behaviours particular to each consultation as it progressed and took no direct part in the interaction other than providing minimal responses if spoken to by another participant (which was rare).

Doctors asked patients' permission to record the consultations for research purposes soon after they had entered the consultation room. In addition, patients had in all cases been alerted to the fact that recordings were being made at the clinic on that particular day. To ensure the protection of confidentiality and patients' privacy under any special circumstances that might have arisen, doctors were given discretionary rights to stop the recording if they felt that the procedure at any point constituted too great an intrusion. Patients readily granted permission in all but one case, and the recorder was turned off on two occasions, when patients became ill or upset during the consultation; these interactions were excluded from the corpus. All details of these procedures were endorsed by the relevant Medical Ethics Committees of the Local Health Authority in advance.

The ideological climate within which the clinic operates is an important contextual dimension to which we appeal in some of our interpretations (this issue is discussed in more detail in J. Coupland and Coupland, in press; and N. Coupland and Coupland, in press). In summary, our interviews with participating doctors suggest that the clinic is highly 'progressive' in its approach to geriatric medicine. Its staff acknowledge geriatrics to be, historically, an undervalued and even discredited arena of medical practice in the UK. In conspicuous opposition to this trend, medical staff at the clinic articulate the priorities of their institution as being to rebuild the reputation of geriatric care and resist ageist practices in medicine. Holism features explicitly within this ideology, and in our interviews with them, staff locate environmental, social and personal circumstances firmly within the remit of health provision for older people. Staff acknowledge that patients attending this clinic may be treated differently here than in other, medically more specific (e.g. cardiac or renal) clinics, by virtue of the holistic emphasis.

5. THE SEQUENCING OF CONSULTATION OPENINGS

All of the consultation openings, which we concentrate on in this paper, show some phatic orientation. Consultations are uniformly initiated with some form of propitiatory sequence (in Laver's sense), in which doctors and patients pursue socio-relational goals, however briefly. Typically, phatically designed talk occurs prior to the establishment of specifically 'medical' business, although we noted earlier that this analytic distinction can be difficult to sustain. Occasionally, a doctor will be reviewing a patient's medical history, audibly and in the hearing of a patient, before s/he instigates a how are you? (HAY?) sequence. Also, a patient may be talking about medical concerns to a nurse on entering the consultation room (where the doctor is waiting), prior to a HAY?-type exchange with a
doctor. But prototypically ‘phatic’ sequences are, in a very clear majority of instances, initiatory.

At one level, phatic exchanges themselves work in the service of doctors’ and patients’ instrumental goals. The data clearly show that participants need to establish a relational basis, however minimally, on which to proceed to whatever medical priorities they have for their encounter. Via phatic sequences too, doctors can also derive indexical cues (relating to mood, self-presentation or morale) which may relate in important ways to the holistic agenda they are committed to.

Extracts 1–6 illustrate typical sequential characteristics of the consultation openings:

Extract 1

(Tape 18; Patient 51 [female, aged 83]; Doctor F [male])

1 **Doctor:** good morning (.) come and sit down
2 **Patient:** thank you (door closes)
3 **Doctor:** Mrs Morris?
4 **Patient:** yes=
5 **Doctor:** =yes (.) do sit down Mrs Morris

6 **Patient:** thank you
7 **Doctor:** my name is Dr Stevens
8 **Patient:** yes . . .
   (doctor explains the research interest and obtains consent to record)
9 **Doctor:** fine (clears throat) tell me about yourself Mrs Morris

Extract 2

(Tape 30; Patient 78 [female, age 77]; Doctor E [male])

1 **Doctor:** hello there
2 **Patient:** morning
3 **Husband:** morning
4 **Doctor:** morning (1.0) do sit down (12.0) won’t keep you a minute
5 just look at your notes (2 minutes) right (.) tell me
6 how you’re feeling now Mrs Meadows

Extract 3

(Tape 33; Patient 86 [male, age 87]; Doctor G [female])

1 **Doctor:** hello do come in (.) Mr Dawes (3.0)
2 **Patient:** thank you (2.0)
3 **Doctor:** do seat yourself down (1.0)
4 (to patient’s daughter) would you like to have a seat as
5 well?
6 **Daughter:** thank you
7 (brief, inaudible talk between doctor and nurse)
8 **Doctor:** seat yourself down (2.0) do sit down (2.0) would you like
9 me to take you (.) can I just take your (1 syllable))
10 **Patient:** ((no use for it))
11 **Doctor:** no we don’t want that do we
12 **Patient:** no!
13 **Doctor:** you have that (.) it’s getting a bit cold (.) I’m Dr George we
14 haven’t met before because I’ve only just started working

Downloaded from das.sagepub.com at PORTLAND STATE UNIV on October 22, 2015
for Professor Harris

Patient: oh yeah

(doctor introduces study)

Doctor: good now how are we doing? how has it been going with

you?

Extract 4

(Tape 14; Patient 41 [female, age 87]; Doctor H [male])

Doctor: (brightly) hello there! (1.0) (door shuts)

to son, quietly) hello

Son: hello

Patient: hello doctor (groans slightly, while sitting down)

Doctor: hello Mrs White (1.0) take a seat

[ ]

Son: I'm her (. I'm her son

Doctor: (to patient) Dr Milward pleased to meet you and (.)

[ ]

Doctor: pleased to meet you (. doctor

Doctor: (to son) pleased to meet you (looking at notes) just

having a quick look at things here (5.0)

Patient: (moans quietly)

Doctor: (very loudly and clearly) well you certainly had a (.)

complicated course in hospital (. but (. you look quite

well now (. how are you feeling?

Extract 5

(Tape 35; Patient 96 [male, age 71]; Doctor H [male])

Doctor: hello sir

Patient: hello

Doctor: Mr Upton I'm Dr Milward (2.0) I think I saw you when you

were in hospital before

Patient: yes er (3.0)

Doctor: anyway let's have a look here (doctor examines notes) (16.0)

right how have you been?

Extract 6

(Tape 15; Patient 48 [female, age 71]; Doctor H [male])

Doctor: (brightly) hello Mrs Howard (. nice to see you

[ ]

Patient: hello

Doctor: you remember me of course

Patient: yes I do (1.0)

Doctor: just two seconds (doctor reads notes) (45.0) right (.)

how have you been?

A restricted set of exchanges.recur in these openings, with a general sequential preference appearing. Numbered exchange-types in Figure 1 form an ordered series that approximates a norm for these consultation openings. Of course, not all exchange-types occur in all encounters, and
there is variation in sequencing. Exchanges can, again, be embedded within others: for example, in Extract 1 where dispositional talk is embedded within familiarity talk. Bracketed exchanges are less common and we discuss them after the ‘core’ exchanges.

summons/approach
 greetings
 (welcomings)
dispositional talk
 (apologies)
familiarity sequence
 (compliments)
 (environmental talk)
 (teases)
 holding sequence
 how are you?-type exchange

FIGURE 1. A candidate exchange sequence for consultation openings.

Similar to the findings in Heath (1981, 1984), consultations come to be opened after a summons by either the doctor or a nurse, leading to the patient entering the consulting room. (There are often inaudible from the audio-record of our data, where they are offered mainly by nurses, outside the consulting room.) Following the summons/approach, a greetings exchange is almost ubiquitous as the first verbal exchange, with very few instances of patients initiating them (see all six extracts). Dispositional communication and/or a familiarity sequence commonly follow the greeting sequence. Dispositional communication is talk directing the patient (and often an accompanying third party) to sit down and be comfortable (Extract 1, lines 1–2, 5–6; Extract 2, line 4; Extract 3, lines 1–12; Extract 4, line 5). When a conventional greetings sequence does not occur, dispositional talk as first exchange appears to function adequately as a greeting substitute, as in Extract 7:

Extract 7

(Tape 33; Patient 87 [female, age 85]; Doctor G [female])

1 Doctor: do come in (3.0) would you like to have a seat? 

   [ ]

2 Patient: ( (thank you)) thank you

3 Doctor: yes I’m sorry you had to wait so long .) have a

4 seat .) apologies from us we are still trying to find

5 the results of that test

The familiarity sequence, again almost always initiated by the doctor, serves to establish a sense of mutual pre-knowledge concerning (1) the identity of the doctor for the patient (see Extract 1, lines 7–8; Extract 3, lines 13–16; Extract 4, lines 7–8; Extract 5, lines 3–5; Extract 6, lines 3–4); (2) the identity of the patient and accompanying third person for the doctor (see Extract 1, lines 3–4; Extract 4, lines 6 and 9); and/or (3) the relationship between doctor and patient, including previous meetings or reasons why this doctor rather than another is involved (see Extract 3, lines 13–16;
Extract 5, lines 3–5; Extract 6, lines 3–4). Doctors’ naming of patients (Extract 2, line 6; Extract 3, line 1; Extract 4, line 5; Extract 5, line 3; Extract 6, line 1) itself establishes rapport, although a patient’s name will most often be available to a doctor through the medical records and the clinic attendance list rather than by memory.

Doctors may read patients’ medical records in their presence. If so, doctors need to put their patients ‘on-hold’ (cf. Hopper, 1992) while they scan or re-scan the notes. Doctors’ reading of medical records was indicated in the ethnographic field notes of participant-observers. But there is often a verbal acknowledgement by the doctor, excusing the extended silences that follow, and serving in practice as a floor-holding mechanism (see Extract 2, lines 4–5; Extract 4, lines 9–10; Extract 5, line 6; and Extract 6, line 5).

A doctor’s HAY? elicitation occurs in 80 of the 85 consultation openings, and many incorporate several instances. We consider variation in the form and placement of HAY? utterances and their discursive consequences below as the principal analytic concern of the paper. But it is already clear that HAY? commonly occurs after the holding sequence (if that sequence occurs) and as a potentially final element of the opening phase as a whole (see the final turns of Extracts 1–6). In many of its realizations, HAY? establishes the possibility of frame transition, or a shift in activity types (Levinson, 1992), out of phatically designed, preliminary, socio-relational talk into the transaction of the medical ‘business at hand’. The reading of case notes, as an acoustic lacuna and as a shift of physical activity and perceptual focus within opening phases, offers a natural transition space. It makes a following HAY? elicitation readily hearable, in the context of a medical consultation, as a request for a subjective self-assessment that is relevant to medical diagnosis.

But before considering this transition in more detail, we should note that participants can supplement the ‘core’ opening exchange-types with several others. Welcomings are often embedded in doctors’ greeting turns, generally in the form of nice to see you, or pleased to meet you, and are sometimes audibly reciprocated (see Extract 4, lines 7–9; Extract 6, line 1; and Extract 8, below, lines 3–4).

Extract 8
(Tape 15; Patient 43 [female, age 67]; Doctor H [male])
1 Doctor: hello Mrs Grady
2 Patient: hello
3 Doctor: nice to see you again
4 Patient: yes (.) and you

Other moves, still occurring before a hold sequence and/or the first HAY? exchange, include apologies about the management of the encounter, as in Extracts 9 and 10:

Extract 9
(Tape 15; Patient 46 [female, age 82]; Doctor H [male])
1 Doctor: hello Mrs Mapp
2 Patient: hello
3 Doctor: sorry to keep you waiting so long (.) (but) the X-ray
4 made things a bit slower that's all (1.0)
5 Patient: yes

Extract 10
(Tape 01; Patient 06 [female, age 97]; Doctor F [male])
1 Doctor: good morning
2 Patient: good morning doctor
3 Doctor: have you been waiting long?
4 Patient: no er (laughs)

5 Doctor: sorry about that

6 Patient: no no not long

7 Doctor: been a bit busy today=
8 Patient: =yes

There are also personal appearance compliments, as in Extract 11:

Extract 11
(Tape 24; Patient 65 [female, age 72]; Doctor C [female])
1 Doctor: good morning
2 Patient: (brightly) hello doctor

3 Doctor: you (.) you look very smart (.) as usual
4 Patient: pardon?

5 Doctor: take a seat (.) you look very smart
6 Patient: oh thank you very much!

This compliment addresses 'non-medical' attributes, though, in line with our earlier argument, it is not necessarily unrelated to (holistic) medical concerns. Within obvious limits, demeanour indexes at least a threshold level of environmental coping. A large class of similar acts do not qualify as compliments because they signify more readily within a medical frame (e.g. you look quite well now, in lines 13–14 of Extract 4, above).

Comments about the local environment, including temperature and weather, as in Extracts 12–13, are often cited as prototypes of phatic communion (e.g. in Malinowski, 1923).

Extract 12
(Tape 21; Patient 63 [female, age 83]; Doctor A [male])
(The doctor has called the patient and is helping her into the consulting room)
1 Doctor: perhaps if you sit down there Mrs Elias

2 Patient: yes

3 Doctor: here we go (2.0) OK I'll just close the door
Patients appear to feel it legitimate to initiate this class of ‘environmental’ exchanges, possibly because they are so clearly formulaic and require only minimal corroboration by the doctor. On the other hand, patient 02’s accompanying wife inquires about the doctor’s holidays, in Extract 14:

Extract 14

(Tape 01; Patient 02 [male, age 74]; Doctor F [male])

1 Patient: (very quietly) ((morning))
2 Doctor: morning
3 Wife: good morning (door closes)
4 Doctor: morning
5 Wife: you enjoy your holidays?
6 Doctor: yes thank you
7 Wife: that’s good
8 Patient: ((very nice))

Dr F’s tease, in Extract 15 (which is a later segment of the previous interaction), and the laughter that follows allow participants to achieve an intimacy within a geriatric medical context precisely by subverting the medical definition of that reality. (We have discussed the professional and moral issues implicated in this and other age references in the data in another place—N. Coupland and Coupland, in press).

Extract 15

(Tape 01; Patient 02 [male, age 74]; Doctor F [male])

(After a reciprocated greeting, the patient has audibly struggled to sit down)

1 Doctor: (to patient, teasing voice) oh! (1.0) you’re not getting old are you?
2 Patient: yes
3 Doctor: you are?
4 Wife: (laughs at length)
5 Doctor: (chuckles)

As Schegloff (1986) notes, a primary achievement of conversational openings is the constitution and reconstitution of the interactants’ relationship for the present occasion. Greeting and welcomings, dispositional talk,
apologies, the familiarity sequence, compliments, teases and environmental talk all play some part in this achievement. Together, they constitute a predominantly social frame for consultation openings, where relational concerns are given precedence over (at least overtly) instrumental medical concerns. At the same time, these processes are, for the most part, highly conventionalized, and conventionality is a key attribute of all phatic talk. We have argued elsewhere that one of its defining characteristics is in fact the systematic ambiguity that it encodes (J. Coupland et al., 1992). In medical consultations, fringing formulas (very largely instigated by doctors) are unlikely to be taken to signify more than minimally expectable concern for physical comfort (distributional talk, apologies) and relational continuity (welcomings, familiarity sequences). The occasional instances of compliments and teases do transcend conventional norms of politeness. But all of these moves necessarily contrast with their absence, and doctors presumably need to ensure that they can be heard as expressions of genuine, personal involvement and concern. Without this possibility of the relational frame being mutually and meaningfully endorsed early on in these encounters, we could expect later, ‘medically salient’ exchanges to be highly face-threatening. But in ensuring plausible hearings of socio-relational involvement, doctors have already, in small ways, begun their professional work of engaging with the ‘lifeworld’ of their elderly patients.

6. PROFESSIONALS’ AND PATIENTS’ FRAMING PRIORITIES

A plausible assumption in any institutional medical setting is that participants will, or should, orient at some point to some medical business at hand, which will, or should, be constituted as the business in hand. This assumption is explicitly referenced in Extract 16:

Extract 16

(Tape 25; Patient 71 [male, age 81]; Doctor C [female])

(The extract follows a greeting sequence and dispositional talk)

1 Doctor: how are you?
2 Patient: well I’m very well really
3 Doctor: very well yes you look very well yeah

4 Patient: yes (ah you are) thinking
5 I’m coming here under false pretences (laughs)

6 Doctor: (laughs)
7 Patient: no. (. ) I I really feel ( (up doctor))

8 Doctor: I don’t
9 hah how young are you?
10 Patient: pardon?
11 Doctor: may I ask you how young are you?
12 Patient: how young?
13 Doctor: yes
[14 Patient: eighty one
15 Doctor: eighty one years young (.) that's no age (7.0) (doctor
16 rustles papers, looking at notes) what did you do before
17 you retired? (.) what kind of job?
18 Patient: well er (1.0) I went into an office actually for ten
19 years before I (1.0) er (.) I was a filing clerk for
20 ten years but before that I had a trade
21 ]
22 Doctor: filing clerk
23 what kind of trade?
24 Patient: er a wood machinist in the building trade
25 Doctor: oh! (11.0) do you have a wife at home?
26 Patient: yes I have I got one of the best wives in the world=
27 Doctor = oh I'm sure how young is she?
28 Patient: she's seventy six (1.0) and believe me (.) you've seen
29 her I believe she er (.) had a major heart (.) operation
30 last year (1.0) under Dr Pickering (1.0) in the (name of
31 hospital)
32 Doctor: I probably have seen her yes
33 Patient: and er (.) she's marvellous with it (2.0) she's seventy
34 six actually
35 Doctor: and she's (.) doing all the housework? who does the
36 cooking?
37 Patient: oh I I I (.) she does the cooking I do the housework
38 Doctor: oh good (.) division good division of labour (.) right
39 (.) er right (.) now (.) any problem? (.) anything I can?
40 Patient: problem?
41 Doctor: mm (.) anything I can't erm (.) anything that (.) erm
42 Patient: oh about myself you mean?
43 Doctor: yes yes
44 Patient: well (.) er (.) I get tired (.) rather quickly but I
45 of course I (.) I'm not getting younger am I? I mean
46 Doctor: well nobody gets younger but (.) er that's not the reason
47 that you should get tired

Several of the patient's utterances in this extract imply that medical
cconcerns are, for him, the principle rationale for the encounter. He raises
the possibility of adjudged false pretences (line 5)—that his presence at the
clinic may not be warrantable because he is very well really (line 2). The
keying of this remark (said with simultaneous laughter) disguises his com-
mitment to the observation, which is also true of the doctor's position,
since she laughs simultaneously (line 6). But the doctor's ideological posi-
tion on what warrants attendance at the clinic is clarified in her subsequent
turns. She is prepared to develop talk on socio-relational themes, including
asking about the patient's age, his previous job, his marriage, his wife's
age, and the sharing of household responsibilities (up to line 37 of the
extract). During these exchanges, it is the patient who introduces a medical
agenda in talking about his wife's major heart (.) operation (line 28), a topic
which the doctor allows to lapse at line 34.

The extract exemplifies the holistic priorities espoused by the clinic staff,
encouraging patients to give accounts of very wide-ranging aspects of their

Downloaded from das.sagepub.com at PORTLAND STATE UNIV on October 22, 2015
circumstances and their relationships. The doctor does, however, move on to probe for disclosure of any problem (line 38) in a turn that is very heavily marked as a transition point: (.) right (.) er right (.) now (.) any problem?. It is the fact of transition (unspecified) that is marked, and the open-endedness of the doctor’s any problem? elicitation is in itself not a guarantee of frame shift, except through a tacit appeal to the patient’s own assumptions about legitimate practice. That the patient interprets the transition as a frame shift is confirmed by his asking for clarification that the problem probe relates to personal medical matters (line 41), and he goes on to tell of how he gets tired rather quickly. In this extract, then, there is a suggestion that the holistic ideal is to allow specific discourse space for the articulation of social and environmental dimensions of a patient’s general experience; but possibly also that there are constraints on the viability of the relational frame unless it is to provide a context for more ‘traditionally’ bio-medical concerns.

Occasionally, doctors’ willingness to pursue non-medical topics is strikingly at odds with the findings of most previous studies (see the earlier review). For example, Extract 17:

Extract 17

(Tape 12; Patient 31 [female, age 76]; Doctor B [male])
(Immediately after a greeting sequence, dispositional talk and a familiarity sequence)
1 Doctor: where did you get the (.) the ((armband))?
2 Patient: which one? (.) which one?
3 Doctor: the gold one?
4 Patient: gold one? (.) why?
5 Doctor: yeah
6 Patient: Saudi
7 Doctor: Saudi?
8 Patient: ((sau er)) (.) that’s their er (.) emblem
9 Doctor: that’s right (.) yeah
10 Patient: ((got a)) son there
11 Doctor: your son?
12 Patient: he got a big jobs you know
13 Doctor: has he?
14 Patient: he’s goes round doing big jobs his own business
15 Doctor: that’s erm
16 right
17 Patient: he was out there for four months
18 Doctor: and he brought you home that?
19 Patient: and see the only thing about it they
20 couldn’t have a (.) a drink out there (.) and there’s
21 no drink out there see
22 Doctor: yeah (.) no Brain’s Dark (a local
The doctor has opportunities throughout lines 1–25 to pose a HAY? or somehow move into a medical frame, but instead expands into social topics, with the conversation quickly achieving a surprising intimacy. The doctor’s inquiry about the armband at line 1—possibly an anomaly of pure curiosity—occurs where either a holding sequence or a HAY? (or both) could be expected. At line 7 (once the response to the doctor’s line 1 elicitation and the embedded elements of the pair are complete) the doctor is in a position to move on to medical affairs, but instead invited the patient to continue. After the patient’s response in line 8, and the doctor’s third-position assessment in line 9, the patient takes the floor and develops several accounts of her son’s life in Saudi Arabia. The doctor provides support for these accounts with clarification requests and expressions of interest (your son?, in line 11; has he? in line 13; and he brought you home that?, in line 18). Eventually he poses a HAY? at line 25. Although the apparent medical business at hand is deferred by this sequence of accounts, the patient has raised two socio-relational themes that may be diagnostically informative at some later point—alcohol and family support. Because they have surfaced in ‘informal’ talk, the doctor may feel it is easier to reinstitute them as topics for later ‘medical’ consideration, should this prove appropriate.

7. POSITION ONE UTTERANCES: FORMAL VARIATION IN HAY?-TYPE ELICITATIONS

We suggested earlier that a movement into specific, medical, problem-oriented concerns is predictably, but not inevitably, achieved with the first HAY?-type elicitation by a doctor, bolstered by certain contextual/sequential considerations (which we shall examine in detail in later sections). In this section we examine the formal alternatives available to doctors in the corpus in the formulating of their HAY?s. We take HAY?s to be the set of doctors’ elicitations which require patients, in their responses, to articulate a version of their health, well-being or ‘state’, necessarily subjective, in more or less specific terms. For Heath, HAY?s are included in the class he calls ‘first topic initiators’:

[F]irst topic initiators are sequentially implicative for the start, by the patient, of talk concerning his illness or more generally, troubles. (1981: 75)

(Button and Casey, 1984, similarly discuss topic initial elicitors.) When we refer to HAY?s as position one utterances we mean that they are the first turns of two- or three-part exchanges, potentially leading to the topologicalization of a specific medical trouble, which may be perceived as the business at hand. After all, HAY?s are asked in the context of extremely plausible
and, in many cases, known health problems. But HAY?s have the potential for being interpreted (at one extreme) phatically or (at the other) non-phatically, as 'genuine' health appraisals or updates on symptoms, etc.

The lexico-grammatical and prosodic formatting of HAY?s is interestingly varied, and this variation is able to encode degrees of closed-endedness. In its lexico-grammatical form, how are you? is maximally open-ended; it bears the sequential ambiguity (Schegloff, 1984) we highlighted in the earlier study (J. Coupland et al., 1992). Participants may deem either routinized, low-discursive and 'suspended' responses, perhaps marked for politeness, or more 'committed', fact-based responses, appropriate.

Among the 85 interactions we are studying here, within consultation openings, doctors' HAY?-type utterances feature in 80 cases. In the remaining 5 cases, patients themselves establish their own medical circumstances as topics without a doctor's first elicitation. Within the 80 instances, there are 54 where the doctor's HAY?-type utterance precedes the establishment of any talk on an explicitly medical theme. Therefore, in the majority of cases (the 54), doctors' HAY?s either appear as an element of early socio-relational exchanges or mark potential transitions out of socio-relational and into medically framed interaction. That is, the 54 cases conform to the candidate sequence we identified in section 5 of the paper.

7.1 Canonical forms

As regards linguistic realizations, 23 of the initial 80 HAY?S appear in the canonical lexico-grammatical form, including:

- how are you? (no primary stress) (e.g. patients 21, 35, 62, 115)
- how are you? (patients 5, 64, 71)
- how are you? (patient 113)
- how are you sir? (patients 29, 81)
- how are you Mrs Wilson? (patient 37)
- so how are you? how are you? (patient 88)

Our transcription of these and other fragments gives a very approximate specification of one aspect of prosody—primary stress placement. Details of prosody, along with the contextualization details we consider in the next section, can function powerfully to project a particular framing of HAY? On the other hand, the multiple contextual considerations we are considering make it implausible that systematic correlations between the prosodic forms of HAY?S and the framing of following responses can be found.

The framing of HAY?S and their responses will be sensitive to many further dimensions of their realization. Within the data, we can identify the following (overlapping) categories of non-canonical realizations:

7.2 Invoking telling

Examples of this category include:

tell me about yourself Mrs Morris (patient 51)
tell me about yourself you haven’t seen me for a long time now two years
(patient 54)
tell me about um (. ) Mrs Casey (louder) can you tell me about yourself?
(patient 8)
tell me how you’re feeling now Mrs Meadows (patient 78)
tell me dear how are you feeling today? (patient 117)
you better tell me how you are getting on (patient 87)

These formats are pre-disclosive at least in that they impose a stronger
requirement to present some rather substantial personal account. Telling
need not, of course, be medical telling, and the tell me about yourself
format is entirely consistent with the holistic ideology of geriatric care.
Still, a substantial version of oneself in the context of an outpatients clinic
may well be assumed by patients to be more legitimate if it is medically
framed. The relative open-endedness of invoking telling is confirmed by
the fact that it is particularly characteristic when the patient is making a
first visit to the clinic, or a visit after a long period of absence.

7.3 Invoking affect

Examples of this category include:

how are you feeling? (patients 43, 46, 101, 103)
how are you feeling today? (patients 77 and 116)
how do you feel in yourself? (patient 20)

The feel format again allows patients to represent (a version of) their
affective responses to a wide variety of personal circumstances, whether
traditionally within the bio-medical frame or not. Unlike the formats we
have considered this far, it does, however, require an explicitly self-evalua-
tive response. In the UK context, the in yourself tag is a conventional
means of restricting the evaluation to supposedly ‘internal’ (and so more
predictably ‘medical’) dimensions of ‘how one feels’.

7.4. Temporal specification

Several of the above examples tie the response to a specific timeframe.
Commonly specified dimensions are as follows:

(1) present tense reference, e.g:
how are you now? (patient 65)
how are you today? (patients 79, 92)
how are you this morning? (patient 114)

(2) perfect tense reference, e.g:
how have you been? (patients 36, 40, 45, 96, 102, 104)
how have you been since you’ve been home? (patient 73)
how have you been since I saw you last? (patient 13)
how have things been? (patient 97)
(3) focus on progression, e.g:
   how are you getting on? (patients 30, 75, 106)
   how are you doing? (patients 31, 90)
   how is he doing? (patient 69)
   how have you been doing? (patient 76)
   how have things been going? (patients 42, 85)

The implications of present time reference are ambiguous. To the extent that a patient is asked to represent only how s/he is currently, s/he may be absolved from reporting on any chronic current or past problem, e.g. a known medical condition. At the same time, now, or this morning predictably identify the present physical situation, and so 'how one is' in and for the medical context. Both the perfect and the various progressive formats require a self-appraisal that relates to a specified or implied span of time, and so a general gloss. The references since you've been home or since I saw you last may well be taken to imply a medical context. Otherwise, all the quoted instances are sufficiently conventionalized to be able to operate in either medical or socio-relational frames.

7.5 General problems format

Examples of this category include:
   what's the problem? (patient 2)
   hm! you're not very well this week (. ) no (patient 3)
   you were not well in your daughter's? (patient 22)

7.6 Specific health problems format

Examples include:

   the main reason for seeing you this time was to (. ) check on how your
   walking's been and if you've had any more falls (patient 39)
   you've been having a lot of pain in your legs (patient 57)
   is it fair to say that we've been seeing you here b (. ) because of the (. ) of
   the (. ) funny heads you've been having? (patient 58)
   you sound very out of breath (patient 89)
   I understand (. ) the main problem (. ) it's the pain in (. ) the hip (patient
   82)

These last two subcategories contain doctor elicitations which are unambiguously medially framed. But it is illuminating to notice that they are only two of a far larger set of doctors' first elicitations in the corpus we are examining.

8. SEQUENTIAL CONSTRAINTS ON THE FRAMING OF HAY?S

In section 4, and with reference to Extracts 1–6, we noted that doctors' HAY?s are often placed in consultation openings so as potentially to
achieve a transition into a medical frame. We also noted how the physical
disruption of talk when the doctor consults case notes, sometimes with an
associated (verbal) holding exchange, consolidates the role of HAY? as a
possible frame-shifting device. Discourse markers in the vicinity of a
HAY? provide further support. Markers that Sinclair and Coulthard
(1975) identified as ‘framing moves’ in the organization of classroom
discourse are common first elements of turns containing HAY?s: for example,
*fine, right, good, now, well* and *anyway* in Extract 1, line 9; Extract 2, line
4; Extract 3, line 18; Extract 4, lines 12–14; Extract 5, lines 6–8; and
Extract 6, line 5. In Extract 18, the doctor marks both the onset and ending
of the note-examining long pause with *right*.

Extract 18

(Tape 14; Patient 36 [male, age 80]; Doctor H [male])

(Following a greeting sequence and dispositional talk)

1 Doctor: right (1.5) now let’s just have a look at things here
2 (9.0) right how’ve you been sir?
3 Patient: well (.) er (.) alright till about th (.) two and a
4 half weeks ago (.) I got up in the morning and I’m
5 (.) and a (.) pain in the back (.) and it g (1.0) i
6 in the afternoon it got very bad (.) right up my back

Paralinguistic cues, such as the doctor markedly drawing breath or throat-
clearing before posing the HAY?, can similarly signal the anticipated onset
of ‘more significant’ exchanges, and so possibly a change of frame. The
pre- or post-marker *anyway* relegates prior topics of talk to being non-
current and may correspondingly establish the present elicitation as relating
to participants’ ‘real’ concerns (see Extract 5, line 6; Extract 17, line
25). Non-vocal signals (to which we have no access in the present data) can
make a further contribution.

HAY?s can accompany other utterances that help establish frame
changes. After (or during) the holding sequence, but before HAY?,
doctors may audibly summarize facts from the medical record in a confirm-
atory, medical preamble to the elicitation itself, briefly (as in Extract 19) or
at length (as in Extract 20). Following HAY?s are thereby predictably
narrowed from more general to more specific elicitations.

Extract 19

(Tape 14; Patient 37 [female, age 85]; Doctor H [male])

(After a greeting sequence, dispositional talk, and a familiarity
sequence)

1 Doctor: good (2.0) erm (looking at patient’s notes) (2.0) right I
2 notice that we had a but of a slow (1.0) noted a bit of a
3 slow pulse when you were in hospital (.) have you had any
4 problems since you’ve gone home?

Extract 20

(Tape 39; Patient 106 [female, age 84]; Doctor D [male])

(After a greeting sequence and a familiarity sequence)
Discourse & Society

1 Doctor: (quietly) ((several syllables)) would you like to take a seat ((Mrs Marsden)) that's right (1.0) now then (.) erm (2.5) you er (.) you came into hospital (.) er in se in
2 er (.) nineteen eighty six wasn't it in er
3 Patient: in Llandough
4 Doctor: in Llandough right (.) and that was er (.) you'd had a heart attack
5 Patient: that's right
6 Doctor: and a clot and a clot in your lungs
7 Patient: yeah=
8 Doctor: = and a clot in your leg
9 Patient: yes
10 Doctor: and your heart was going too fast
11 Patient: that's right
12 Doctor: right (1.0) how are you getting on now?

9. Position Two Utterances—Responses to HAY's

It might be expected that the transition from socio-relational talk, via HAY?, to a specific, medical problem-orientation is brief and non-problematic. Heath (1981) in fact notes that even when HAY? is delivered as a greeting substitute, or as part of a consultation opening, patients generally hear and treat the HAY? as inquiring into the problem with which the patient is visiting the doctor. But probably the most significant generalization to emerge from the present data is that brief and easy transitions are very uncharacteristic. As we have suggested above, HAY?'s certainly play a part in facilitating talk within a medical frame. But what we find is that doctor and patient engage in structured work towards achieving that orientation, and that prototypically 'medical discourse' is neither an immediate nor an inevitable sequel to HAY?.

9.1. Phatic responses to HAY?

Several patients in our data do provide phatically designed responses to HAY?, as in Extract 21 (an extended version of Extract 6) and Extracts 22 and 23:

Extract 21

(Tape 15; Patient 48 [female, age 71]; Doctor H [male])

1 Doctor: (brightly) hello Mrs Howard (.) nice to see you [ ]
2 Patient: hello
3 Doctor: you remember me of course
4 Patient: yes I do (1.0)
5 Doctor: just two seconds (doctor reads notes) (45.0) right (.)
6 how have you been?
7 Patient: alright thank you (3.0) I was a bit concerned (.) which
8 was why this (.) appointment was brought forward about er
9 (.) my sugar (.) going up (.) you see

Downloaded from das.sagepub.com at PORTLAND STATE UNIV on October 22, 2015
Extract 22
(Tape 24; Patient 64 [female, age 81]; Doctor C [Male])

1 Doctor: good morning Mrs Grady
2 Patient: (very brightly) morning!
3 Doctor: take a seat (doctor introduces study)
4 Doctor: right (4.0) how are you?
5 Patient: I'm fine thanks
6 Doctor: good

7 Patient: ((ah)) (. ) I got me aches and pains but still

Extract 23
(Tape 45; Patient 117 [female, age 76]; Doctor E [male])

(After a greeting sequence, an apology, and dispositional talk)

1 Doctor: there we are (1.0) (to daughter) hello (10.0) (to
2 patient) I won't be a minute I'll just (.) look through
3 your (1.0) previous (1.0) records dear
4 Patient: (quietly) ((that's right)) (1 minute)
5 Doctor: well tell me dear how are you feeling today?

6 Patient: feeling fine thank you doctor yes

7 Doctor: yes? and (.) how about your
8 aches and pains? have you got any?

9 oh the pain ye yeah I do get it now

10 and again

11

Note that the first responses to HAY? in Extracts 21–3 are, on several
criteria, phatically oriented. Each is a broadly positive, brief and formulaic
assessment of own health. Most significantly, each patient does formulate
specific medical troubles later in each extract, qualifying the valence of the
initial response. None of the extracts shows any specific troubles-premonitory
marker (cf. Jefferson, 1980) of the sort that would predispose further
'diagnostic sequences' (Sacks, 1975) by the doctor. Also, each is ac-
accompanied by a thanking utterance which projects the belief by the patient
that the doctor is showing somewhat unexpected personal concern. Thanking implies that the doctor's HAY? has been interpreted more as a
politeness move—a social ritual—than as an elicitation within a medical
frame (cf. J. Coupland et al., 1992). In Extract 23, the doctor's second
HAY? (lines 8–9) reorients the patient to a more medical formulation (and
( .) how about your aches and pains? have you got any?). And the patient's
reorientation is itself explicitly referenced: oh the pain ye yeah (line 10),
including the change-of-state marker oh (Heritage, 1984).

Clearly, then, there is no guarantee that doctor and patient will effect a
frame shift through a HAY? elicitation, or that they share a frame orient-
ation at the outset of, or during the negotiation of, this exchange. Position
one HAY? utterances that appear to be sequentially organized to enter a
medical frame can be recontextualized by ritualized and phatic position
two responses. Even when we examine position two utterances that do relate to medical concerns, we find that patients’ responses very rarely orient immediately and categorically to the medical agenda.

9.2. Hedging on medical disclosure

If specific medical problems are to be revealed in the patient’s next move after the HAY?, they are likely to be qualified or hedged in some fashion, as in Extracts 24–6:

*Extract 24*

(Tape 18; Patient 50 [female, age 73]; Doctor F [male])

1 Doctor: oh (2.0) how are you?
2 Patient: well very good er (.) still a bit breathless

*Extract 25*

(Tape 35; Patient 97 [male, age 76]; Doctor H [male])

1 Doctor: how have things been?
2 Patient: ah well (2.0) oh I mustn’t grumble (.) but you know
3 you get little things like itching and that don’t
4 you I (laughs briefly) I don’t bother I just put up with
5 it (sighs) but

*Extract 26*

(Extract 18, repeated: Tape 14; Patient 36 [male, age 80]; Doctor H [male])

(Following a greeting sequence and dispositional talk)

1 Doctor: right (1.5) now let’s just have a look at things here
2 (9.0) right how’ve you been sir?
3 Patient: well (.) er (.) alright till about th (.) two and a
4 half weeks ago (.) I got up in the morning and I’m
5 (.) and a (.) pain in the back (.) and it g (1.0) i
6 in the afternoon it go very bad (.) right up my back

Patients’ responses to HAY? in the three extracts above share at least two characteristics. First, each of them adopts a ‘good news–bad news’ format, beginning with a relatively positive formulation then proceeding to detail specific difficulties or discomfort. As we noted in an earlier study of a different corpus (J. Coupland et al., 1992), this response format exhibits real-time variation in the positivity/negativity of a self-appraisal. The first element of the response approximates Jefferson’s (1985) analysis of how troubles-tellers can provide initial ‘glosses’ about how they are that remain to be ‘unpackaged’ subsequently. That the ‘bad news’ is situated after, and in the light of, the ‘good news’ highlights how the initial gloss entails some measure of suspension of commitment (to open disclosure, and perhaps to veracity). Good news–bad news formats therefore organize position two utterances as partly phatic responses. They respect participants’ faces in avoiding ‘bald on record’ self-appraisals (Brown and Levinson, 1987) and mitigate the threat of initial negativity. As Fisher and Groce (1990) note,
patients often account for specific medical circumstances; in Extract 25, the patient minimizes his itching by referring to it as one of a class of little things. The evaluation is also made relative to what is to be expected in later life, and the effect is again to minimize the apparent significance of the complaint (cf. N. Coupland et al., 1989).

Second, each patient prefices the response with a token (such as well or er) indicating that what they might say is reflective and perhaps difficult to formulate (Schiffrin, 1987). Such responses make it clear that they are only versions of other possible self-appraisals. And so, they allow the hearer (the doctor) to infer that more negative versions are available than the one presented (since there are less plausible benefits in representing oneself as worse than one is). Jefferson (1980) similarly notes that pre-markers, such as filled pauses, serve to delay the negativity of a troubles report.

The first elements of many of these responses (after a possible filled pause) are what Jefferson (1980) calls downgraded conventional responses. Patients seem to experience a situation similar to what Jefferson considers a central and recurrent feature of troubles talk generally—the tension of managing the dual relevance of attending both to ‘troubles’ and to ‘business as usual’. Although this is a surprising finding within an institutional, medical social environment, it seems that, at certain points, patients too orient to good health as ‘normal business’. In ‘Extracts 27–9, we again see patients producing the qualified negative self-appraisals (not too bad) that are highly conventionalized as lay HAY? responses in our own cultural contexts.

Extract 27

(Tape 43; Patient 113 [female, age 85]; Doctor E [male])

1 Doctor: how are you?
2 Patient: oh not too bad fair play
3 Doctor: (soothingly) that’s right
4 Patient: I got a bit of pain in my side (. ) here ((that’s all))

Extract 28

(Tape 30; Patient 77 [male, age 75]; Doctor E [male])

(After the doctor asking patient for permission to do the study)

1 Patient: no (. ) no I don’t mind

2 Doctor: ((you don’t)) (. ) that’s kind of you (. ) OK
3

(2.0) well how are you feeling today?

4 Patient: not too bad
5 Doctor: good (1.5) and have you been testing your urine at home?

Extract 29

(Tape 14; Patient 41 [female, age 87]; Doctor H [male])

1 Doctor: (very loudly) well you certainly had a (. ) complicated course in hospital (. ) but (. ) you look quite well now
3 (. ) how are you feeling?
4 Patient: oh I don’t feel too bad doctor but (. ) I could be better
you know what I mean
Doctor: what are the main problems?
Patient: ((uh tu))
Son: well er(.) i it's her ankles doctor her ankles swell
[ 
Patient: er my ankles are ss my
ankles are swell

Jefferson comments that
inasmuch as . . . [the downgraded conventional response] may, but only may, premonitor a report on a trouble, this response is not itself, on its occurrence, the 'telling' of the trouble. It is, on its occurrence, a version of a conventional reply to an inquiry, perhaps shadowed by a trouble—a trouble that may or may not be told. What is being done, on its occurrence, is the routine business of a conversation's opening by one who might or might not have a trouble, which trouble might or might not be told. (1980: 162–3)

With a downgraded conventional response, then, the patient may not be orienting immediately to a medical frame but renders the telling of the trouble negotiable. It seems as if the patient may be holding back, at least temporarily, from the medical frame, providing a response that is, initially, as ambiguous as the doctor's HAY?

9.3 Non-specific problems orientation
There are a few instances in the data where patients initially respond to doctors' HAY's with a specific problem-orientation, as in Extract 30.

Extract 30
(Tape 01; Patient 05 [male, age 78]; Doctor F [male])
(The patient is being helped into the office by a nurse)
1 Doctor: come and take a seat (1.0) come and sit down
2 Nurse: OK? (7.0)
3 Patient: (sighs heavily) (4.0)
4 Doctor: how are you?
5 Patient: oh! (.) blinking hopeless this last three weeks (. ) I
can't hardly walk (.) ((I've)) my (. ) back (1.0) ((it's))
6 (1.0) and my head (.) and my eyes
7 Doctor: mm (1.0)
8 Patient: I'm frightened to go out
9 Doctor: must be the season
10 Patient: ((oh I))
11 
12 Doctor: you know everybody's feeling ill
13 Patient: oh (. ) ((if))
14 Doctor: (laughs)
15 Patient: ((I've had this)) every time they put these injections in
16 my legs
17 Doctor: yes
18 Patient: (( now)) she's stopped it now
19 Doctor: yes
Patient: oh but god! ((let me tell you doctor)) (breathes in) uh
er uh tch if I (1.0) ksit down (.) and
Doctor: what injection is that? (.) for the diabetes?

Following our earlier argument, the doctor’s substantial delaying (for 7 and 4 seconds) of his first elicitation itself predisposes a non-phatic response. The patient gives an immediate and very negative self-appraisal (line 5) which quickly develops into a catalogue of specific physical, sensory and affective problems (lines 6–9). In fact, the doctor at first does not engage with these issues, and locates the reported problems in a broader context: must be the season; you know everybody’s feeling ill (lines 10 and 12). The doctor’s responses echo lay rather than medical priorities. The earlier mm (1.0) (line 8), with flat intonation contour, had already hinted at non-engagement with an offered topic (ten Have, 1991).

A recurring pattern is for patients to respond to HAY? with a negative, non-specific, problem-orientation, as in Extracts 31–3.

Extract 31
(Tape 01; Patient 06 [female, age 97]; Doctor F [male])
(After a jovial initial exchange and permission sequence)
1 Doctor: right (.) fine (.) um (.) how are you feeling now?
2 Patient: not very well at the moment
3 Doctor: not well?
4 Patient: I have a cold and I in myself I feel (breathes) (1.0)
5 (quietly and seriously) very (.) bad

Extract 32
(Tape 36; Patient 102 [male, age 77]; Doctor H [male])
(After greeting sequence and talk about a delay caused by waiting for blood test results)
1 Doctor: well Mr P. how have you been?
2 Patient: well not too good
3 Doctor: you were a bit short of breath last time I believe
4 Patient: yes

5 Wife: yes still is
6 Patient: ((and ye and yet [4 syllables] tend to worry))
7 Doctor: is that your main worry the breathlessness?
8 Patient: ((I do))

Extract 33
(Tape 34; Patient 88 [female, age 88]; Doctor G [female])
(After greeting sequence, apology for waiting time and permission sequence)
1 Doctor: so how are you how are you?
2 Patient: I’m not well
3 Doctor: what’s been the problem?
4 Patient: well I’ve had shingles

First responses of this sort clearly report troubles (not too good), sometimes signalled to be medical (not very well), but they stop short of
accounting for the negative appraisal with any specific reports. They can again incorporate the range of hedges we noted in section 9.2 (e.g. *well* in Extract 32, line 2; and *at the moment* in Extract 31, line 2). So although such responses can be said to ‘medically relevant’ or ‘medically implicative’, even here we cannot claim that a medical frame is clearly in place. Doctors are of course prepared to ‘track’ medically implicative responses (Jefferson, 1980), and have resources to advance the consultation towards specific medical concerns.

10. POSITION THREE UTTERANCES

In what we are calling the third position (doctors’ next-moves to patients’ first responses to HAY?), four general strategies predominate: (1) provide an endorsement; (2) provide a non-specific probe; (3) ask a further HAY?; and (4) set an agenda for the patient. These categories are not necessarily exclusive, and there are theoretically important limitations to assigning functional labels to classes of utterances without considering details of discourse context (cf. Schegloff, 1992) and phonetic realization. On the other hand, these four labels summarize the functional range of position three utterances in the data.

10.1 Endorsements

We have seen that many patients show a preference for offering relatively positive self-appraisals in response to HAY?s, or at least for hedging on their negativity. Such responses in turn allow doctors to express their endorsement of positive self-reports. In Extract 16 (above), after the patient’s upbeat response *well I’m very well really* (line 2) the doctor warrants this judgement by saying *very well yes you look very well yeah* (line 3). In Extract 22, *I’m fine thanks* (line 5) is followed by *good* (line 6); in Extract 27, *oh not too bad fair play* (line 2) is followed by *(soothingly) that’s right* (line 3); in Extract 28, *not too bad* (line 4) is followed by *good* (line 5). Even if patients’ first response glosses are phatic and unwarrantably positive in relation to their later disclosures (see our earlier discussion), doctors capitalize on and prolong their positivity into the third position. The doctor’s flat-contoured *mm* signalling initial reticence to engage with a very negative first gloss (in Extract 30) is in stark contrast.

10.2 Provide a non-specific probe

An alternative is for the doctor to offer a non-evaluative probing utterance (cf. Schegloff, 1982). In the data, probes follow both positive and troubles-implicative responses. In Extract 23 (above), the patient’s *oh I’m . . . feeling fine thank you doctor* (lines 7–8) is followed by the doctor’s *yes* (line 9). In Extract 31, the patient’s *not very well at the moment* (line 2) is followed by the doctor’s *not well?* (line 3).
Doctors’ use of the third-turn probes and ‘continuers’ has been a long-standing point of analysis by those interested in doctor–patient asymmetry. According to Frankel (1984), for example, continuers do not signal to patients what significance doctors have this far attached to patients’ self-accounts. They merely prompt patients to continue or elaborate and have therefore been taken as elements in the reproduction of asymmetry (Atkinson, 1982), and in particular as evidence of doctors’ under-disclosiveness. In fact, the discourse functioning of such items, as we noted above, is highly sensitive to prosodic and non-vocal realization. The term ‘continuer’ is most appropriately applied to non-referring expressions (such as *uh-huh* or *yes?*) said with high-rise contours, or to referring expressions which request patients to elaborate on a summary account (such as *not well*?), said with a fall-rise on the tonic syllable. (Third-position items can equally carry low-falling contours and function to *curtail* further disclosure by patients.)

The precise placement of probes and continuers in a discourse is also a crucial consideration. Probes as third-position moves first signal the doctor’s attentiveness and orientation to the patient’s self-disclosure, and then open-endedly hand the floor back to patients with the option to re-establish or shift the discursive frame.

10.3 Ask a further HAY?

The multi-functioning of HAY’s in medical discourse is most clear when we see the impact of their *serial* placement in consultation openings. Third-(or later)position utterances are quite commonly further HAY’s although these are of course elicitations made in the local context of being *subsequent* HAY’s. That is, even a formally repetitive HAY? is likely to be functionally unique. On the second occasion of its asking the dominant frame may have shifted, and the fact of asking it a second time may itself promote frame change.

Third-position (or subsequent) HAY’s may be more constraining in their forms (see section 6, above) and so encourage patients rather explicitly to orient to a more medical frame. For example, they may overtly refer to ‘problems’, ‘troubles’, ‘pain’, etc. In Extract 23, the doctor’s second HAY? is *and (.) how about your aches and pains? have you got any?* (lines 9 –10). In Extract 29, the second HAY? is *what are the main problems?* (line 6). In Extract 33, it is *what’s been the problem?* (line 3). Just as we saw that initial HAY’s very often bear a systematic frame ambiguity, so there is a tendency for subsequent HAY’s to home in on specifically troubles-oriented, including medical, concerns.

But even a HAY? such as *how are you getting on?*, and even when asked prior to the establishment of any medically framed talk, can be relatively unambiguously implicative of medical issues, as in Extract 34.

*Extract 34*

(Tape 31; Patient 80 [female, age 62]; Doctor B [male] )
1 Doctor; hello Mrs Mallard (. ) how are you? 
2 Patient: fine thank you ((very much))
3 Doctor: ((nice to see you)) (4.0) now (1.0) we met the last
4 time you were here Mrs Mallard back in July (. )
5 Dr Fielding is my name
6 Patient: yeah that’s right I remember
7 Doctor: how are you getting on? 
8 Patient: well I’ve had a few weeks without the shakes but this
9 last couple of weeks it’s come back

The HAY? in line 1 is embedded early in the socio-relational preliminaries and not surprisingly elicits a conventionally positive response. But by virtue of being the non-initial HAY?, how are you getting on? (in line 7) is unlikely to be heard to operate within a phatic frame, even though it directly follows a familiarity sequence. how are you getting on? is an entirely appropriate form to function as a phatic elicitation, but its placement within the discourse loads the expectation that its response should not be a conventional one. Doctor and patient move jointly towards a presentation of the patient’s complaint (West, personal communication), not least through the doctor’s referencing of a previous meeting in the same medical context (lines 3 and 4)

10.4 Set an agenda for the patient

Alternatively, doctors can elect to impose a relatively specific medical agenda at position three explicitly by referencing a medical topic. An example occurs in Extract 32 where, following the patient’s hedged negative response, well not too good (line 2), the doctor establishes talk on the topic of the patient’s breathing problems: you were a bit short of breath last time I believe (line 3). Once established in this way, the medical frame will typically be operative for a substantial number of following turns, and we can find no examples of patients resisting the medical frame in their next moves. Participants do, however, reimpose socio-relational priorities later in the consultations, and a future priority of our own work with these data will be to track these subsequent frame negotiative processes.

11. Overview

We have outlined some of the sequential attributes of medical consultation openings, focusing on how doctors and patients establish and modify interactional frames. Doctors in the corpus do of course confront the biomedical problems of their patients very directly, and specific medical issues concern both parties increasingly predictably as consultations proceed. On the other hand, there do appear to be very significant, multiple socio-relational dimensions to these interactions. Our intention has been to emphasize the multiple means by which both participants routinely sustain a phatic or relational frame for at least portions of their talk together, and
how relational considerations impinge on medical talk in the early stages of consultations.

We have not provided a directly contrastive account, comparing the interactional styles of geriatric and general medical outpatients clinics. So at this stage it is unclear whether we are documenting practices that are specifically characteristic of geriatric medicine, or that are unique to this one clinic, or that are an under-analysed dimension of all medical interaction. We suspect that all three of these interpretations are partly correct.

In our data, at least regarding consultation openings, there is no evidence of pernicious interactional asymmetry and frame conflict. Socio-relational talk is initially normative, and patients as well as doctors play significant parts in negotiating how and when they should move into medically framed talk. Indeed, there are instances when it is patients rather than doctors who first act to move their talk into medical disclosure and diagnosis, and instances when doctors persist with a socio-relational frame when they have clear opportunities to move into medical talk. These findings are contrary to some earlier studies (e.g. Mishler, 1984).

In the context of geriatric medicine, it is not surprising that doctors and patients assert the viability of the socio-relational frame. Swift’s (1991: 301) appraisal of the modern geriatric medical ideal anticipates a rich and differentiated system of care within which issues of relationships, living environments and autonomous functioning should feature as prominently as issues of medical, surgical and psychiatric diagnosis. That is, within (at least the theory of) modern geriatric medicine there is overt recognition that socio-relational concerns are medical concerns. Talk is a key avenue to all forms of medical diagnosis, but it is close to the sole avenue to appreciating patients’ socio-environmental circumstances. So, emphasis will necessarily fall on medical professionals’ openness to the forms of talk in which socio-relational concerns can be expressed. Our data suggest that consultation openings are an important element of this practice and in fact an integral part of geriatric encounters.

Despite its ritualized nature, the how are you? elicitation proves to be involved in rather fundamental relational negotiations. When patients respond to HAY?, even in a medical context, they have to prioritize quite disparate considerations: the need to present a version of ‘how they are’ which is adequately truthful and disclosive for the moment; but also the need to respect the current relationship and minimize threats and intrusiveness (cf. J. Coupland et al., 1992; Sacks, 1975). Many of the patients in our data initially offer relatively conventionalized and positive (or hedged negative) responses. In doing this they may be boosting their own self-esteem and signalling, at least for the moment, a certain resistance to ill-health or other troubles. In Brown and Levinson’s (1987) terms, they also respect the positive and negative faces of doctors, who also work in diverse ways to sustain a phatic frame in these initial exchanges.

Therefore, although they are sequentially peripheral, it seems quite inappropriate to relegate these episodes to the fringes of geriatric medical considerations. Health in old age has much to do with dignity and morale.
Presenting oneself to a doctor as having a certain resilience, and for that matter also a social competence in the rituals of conversational openings, could feasibly be therapeutic in itself. Even when the consultation moves on, as most in the present corpus do, to negotiate chronic and debilitating illness, it will often be enacted within an established relational context. This again is vital since many of the consequences of illness for elderly patients will be felt in and through their social relationships—for example, curtailed mobility and reduced independence. Doctors will need to negotiate medical outcomes in the context of social considerations, just as we see that those in our data introduce medical symptom-telling in that context. In this way, 'the medical in the context of the social' may be a useful preliminary characterization of (at least some instances of) geriatric medical discourse, although, as an ideology, it is difficult to resist as an ideal of all medical practice.

JUSTINE COUPLAND is a lecturer in English Language at the University of Wales in Cardiff. Her research interests are in social interaction, discourse analysis and interpersonal communication. She was awarded her PhD in 1984. She is co-editor of Contexts of Accommodation: Developments in Applied Sociolinguistics and of the forthcoming Handbook of Communication and Ageing. She has also co-authored Language, Society and the Elderly: Discourse, Identity and Ageing and has published 30 articles and chapters in areas of sociolinguistics, discourse analysis, communicative ritual and social gerontology. ADDRESS: Centre for Applied English Language Studies, University of Wales College of Cardiff, Cardiff CF1 3XB, UK.

JEFFREY D. ROBINSON (BA, Communication Studies, University of California at Santa Barbara; MA, Communication Studies, University of Southern California) is currently a PhD student in the department of sociology at the University of California at Los Angeles, CA 90024–9122, USA. NIKOLAS COUPLAND is Reader in Sociolinguistics and Director of the Centre for Applied English Language Studies at the University of Wales in Cardiff. For the session 1989/90 he was Fulbright Scholar and Visiting Associate Professor at the Department of Communication, University of California at Santa Barbara. He has previously published nine books and three journal special issues on topics in sociolinguistics, discourse analysis and interpersonal/intergroup communication. These include Language: Contexts and Consequences (with Howard Giles), and Language, Society and the Elderly: Discourse, Identity and Ageing (with Justine Coupland and Howard Giles). Proceedings of an International Colloquium on Communication, Health and the Elderly, under his co-editorship, appear in the Fulbright Colloquia series.

NOTES

We are very grateful to Candace West, Charles Goodwin and John Heritage for very constructive comments on an earlier version of this paper.
1. This study extends a developing paradigm of research on interaction and inter-generational talk; see, for example, N. Coupland (in press); N. Coupland and Coupland (1990); N. Coupland et al. (1991a and 1991b).

2. The terms 'voice of medicine' and 'voice of the lifeworld' come from Mishler (1984), signifying what we referred to above as the bio-medical perspective of the doctor and the socio-relational perspective of the patient. Fisher (1991), Silverman (1987) and others have critiqued Mishler's views.

3. A grant to Howard Giles and Nikolas Coupland by the Economic and Social Research Council (UK) funded the original phase of this research. Colleagues centrally involved in that work were Howard Giles, Karen Henwood, Karen Grainger and Karen Atkinson. All of these and Penny Oxley contributed to the gathering of the geriatric outpatients data on which the empirical sections of this paper are based. We gratefully acknowledge their vital contribution.

4. We do not intend to commit ourselves to all aspects of, for example, Sinclair and Coulthard's (1975) analytic framework in using the term 'exchange'. However, all the discourse units we list as elements of these openings are organized as exchanges in Sinclair and Coulthard's sense, at least in that each identifies a feasibly paired set of verbal/non-verbal moves, with the first pair-part initiated overwhelmingly often by the doctor.

REFERENCES


Coupland, N., ed. (1993) *Discourse, Institutions and the Elderly*. (Special Issue of *Journal of Aging Studies*.)


