13 Overall Structural Organization

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1 Introduction

If the discipline of conversation analysis were a tree, the topic of overall structural organization would represent one of its first growth rings. Emanuel Schegloff commented that his initial inquiry into openings, begun at least as early as his dissertation (Schegloff, 1967), was “designed to grasp the interactional structure of one critical phase in the overall structural organization of the unit ‘a single conversation’” (Schegloff, 2002: 272, emphasis added), and Harvey Sacks explicitly dedicated his lectures during the Winter of 1970 to giving “a bunch of lectures under the title ‘Overall Structural Organization of Conversation’” (Sacks, 1970a: 157, emphasis added). Despite this, overall structural organization has since received relatively little analytic attention, and thus is still not well understood.

In the introduction to his book on sequence organization, Schegloff (2007: 1) observed:

[T]urns do not follow one another like identical beads on a string. They have some organization and ‘shape’ to them. … One might say that they seem to be grouped into batches or clumps, one bunch seeming to ‘hang together’ or cohere, and then another, and another, etc.

Although Schegloff was referring to turns and their sequence organization, his analogy can be extended to base adjacency-pair sequences of action (hereafter referred to simply as ‘sequences of action’). That is, like turns, sequences of action are also sometimes organized into groups that ‘hang together’ or cohere. For example, there are a variety of social activities that involve multiple, normatively ordered sequences of action, such as: (1) opening a birthday present in the presence of the giver, which involves acknowledging the giver, reading the card, opening the gift, positively assessing the gift, thanking the giver, etc. (Good & Beach, 2005); (2) telling a trouble to a friend or family member, which involves approaching, arriving at, delivering, working up, and exiting from the trouble in particular ways (Jefferson, 1988; Jefferson & Lee, 1980); (3) participating in a ‘completable task’ (e.g., collaborating with other students to answer, in a single written and evaluated document, multiple reading-comprehension questions; Lerner, 1998); and (4) dealing with acute medical concerns during primary-care medical visits, which involves presenting, gathering information about, diagnosing and treating the concern (Robinson, 2003).

The analysis of such supra-sequential coherence has not generally been a central focus of conversation-analytic research, the majority of which has involved a description of the organization of individual sequences of action and their sub-parts, including turns and turn-constructional units. However, as Sacks (1971a) argued, the enterprise of analyzing individual
sequences of action completely ignores how they are, in some cases, part of larger, coherent matters. Sacks suggested that one (but only one) incarnation of supra-sequential coherence is what he called a “big package” (354) or a set of “pre-organized sequences” (355). Other researchers have since used terms such as (social) activity (Heritage & Sorjonen, 1994), project of activity (Jefferson & Lee, 1980; Robinson, 2003), and plan of action (Levinson, this volume). With his use of the qualifier “pre-organized”—which was further informed by his reference to “relatively gamelike situations” (355; on games, see Garfinkel, 1967; Lerner, 1998)—combined with his reference to “sequences,” Sacks (ibid.) foreshadowed the now common conceptualization of overall structural organization as a relatively external source of interactional coherence that ‘reaches into’ sequence organization, turn construction and opportunities for participation (Lerner, 1998: 7); I mean ‘external’ relative to more local sources of interactional coherence (Schegloff, 1998), including the organization of sequences of action (Schegloff, 2007), and even sequences of sequences (such as reciprocal sequences; Schegloff, 2007).

The massively orderly interactional structure of ‘pre-organized sequences,’ or activities, is not sufficiently explained by sequence organization, nor is it reducible to “ad hoc improvisation” (Lerner, 1998: 8). Rather, that coherence is a product of multiple sequences of action having an overall structural organization. As Schegloff (2007: 2, emphasis added) notes, “[o]verall structural organization is a type of sequential [vs. sequence] organization”. Whereas the scope of sequence organization “is the organization of courses of action enacted through turns-at-talk”, “[s]equential organization is the more general term. We use it to refer to any kind of organization which concerns the relative positioning of [units]” (ibid., emphasis added).

This way of conceptualizing overall structural organization might strike readers who are familiar with Conversation Analysis as unconventional. In the literature, overall structural organization is almost always discussed in terms of ‘the overall structural organization of entire, single occasions of interaction,’ and overall structural organization is canonically discussed in terms of one particular (albeit large) unit of interaction (i.e., an entire, single occasion of interaction). However, it is important to register that many different types of interactional units can have an overall structural organization. Although this point is implicit in published work (Schegloff, 1996; Schegloff & Sacks, 1973), it has been made more explicitly in unpublished work (Jefferson & Lee, 1980; Lerner, 1998; Schegloff, 1998). For example, Schegloff (ibid.: 15) encouraged scholars to: “recognize ‘overall structural organization’ not as something for the unit ‘a single conversation’ (or encounter, or session, etc.) alone, but for units like turns, actions (like answering or telling), sequences, and who knows what else as well”. Schegloff (ibid.: 15-16, emphasis added) went on to say:

Units or orders of organization of all sorts (or of only many sorts perhaps) can have—perhaps must have—both: a local organization, which operates via progressivity from one sub-unit to a next, at various levels of granularity; and an overall structural organization. The latter, of course, can only get its work done in the places provided by the former. The former—the local organization—can only get its emergent shaping by reference to the latter—or the several ‘latter’s which operate on it—e.g., the overall structural organization of turns, of sequences, of actions or activities such as telling or answering, of the unit ‘a single conversation,’ and of that sprawling marvel we call ‘a continuing state of incipient talk,’ as though we understood it.

Because research on the overall structural organization of individual (vs. groupings of) sequences of actions, actions, turns and turn-constructional units is virtually nonexistent (but see Schegloff, 1996, 1998), this chapter reviews findings pertaining to the overall structural organization of more than one sequence of action, as well as of larger units of interaction (e.g.,
entire, single episodes of interaction). The remainder of this chapter is organized as follows. First, I discuss the concept of activity, which, I argue, involves an overall structural organization. The size and scope of activities, and thus of overall structural organizations, can vary. This section provides two exemplars: one of a relatively small activity (that of opening interaction) and one of a relatively large activity (that of primary-care physicians and patients dealing with acute medical concerns). This section also discusses the reflexive relationship between activity pattern and production. Second, I discuss the overall structural organization of entire, single episodes of interaction.

2 Activity

Even within Conversation Analysis, there is no clear or precise conceptualization and definition of activity, at least relative to concepts such as ‘turn’ and ‘sequence’.

However, one common theme is that activities are achieved across more than one sequence of action “which are nonetheless being managed as a coordinated [or coherent] series that overarches its component pairs” (Heritage & Sorjonen, 1994: 4; see also Lerner, 1998). According to Levinson (1992: 69, emphasis in original), activities are associated with particular sets of inferential schemata that inform the nature and organization of their sub-parts (i.e., sub-courses of action), which are “goal-defined ... events with constraints on participants, setting, and so on, but above all on the kinds of allowable contributions” (see also Levinson, this volume, on action). For Levinson, activities range from culturally recognized events that occur within single interactions (e.g. Labov’s (1972) discussion of ‘sounding’) to entire single interactions (e.g. a telephone call).

Prior conversation-analytic research has emphasized the description and explication of forms of interactional coherence (Heritage & Sorjonen, 1994; Lerner, 1991; Schegloff, 1990) that transcend, yet operate on, multiple interactional units the size of sequences of action or larger. In these terms, the sin qua non of activity is the existence of an overall structural organization. This perhaps explains the relative lack of clarity and precision regarding the conceptualization and definition of activity as a unit of interaction, because activity gets its coherence from overall structural organization, which can vary.

This brings us to several important methodological points. Conversation-analytic investigations of overall structural organization are emic in character, focusing on “how the participants display an orientation to [overall structural organization] as a coherent undertaking and as something that may be ‘departed from’ and ‘returned to’” (Heritage & Sorjonen, 1994: 4). Conversation analysts attempt to demonstrate that, and how, a claimed overall structural organization is both relevant to, and procedurally consequential for, participants (Schegloff, 1992). This approach allows analysts to characterize frameworks of coherence (some prior characterizations have been ‘goal,’ ‘agenda,’ ‘single episode of interaction,’ ‘game,’ etc.) and their cohering sub-parts (some prior characterizations have been ‘topic,’ ‘task,’ ‘action,’ ‘stage of a game,’ etc.) in ways that are meaningful/relevant for participants (vs. solely analysts). Finally, conversation analysts proceed with the recognition that aspects of overall structural organizations can vary in terms of their intersubjectivity relative to participants. Some aspects may be familiar to all participants, while others may be familiar only to one (Jefferson & Lee, 1980; Lerner, 1998). Although non-mutual understanding appears to be much more common in institutional contexts—such as calls to 911 (Zimmerman, 1992) and court proceedings (Maynard, 1984)—it can occur in mundane contexts as well, as suggested by Jefferson and Lee (1980: 72):
It is possible that, especially for ‘big packages’, and for those big packages which are not used N times a day each and every day; i.e., such big packages as that by which Troubles-Talk might be organized, no one has had step by step explicit, overt training in the proper procedure.

In the remainder of this section, I present two exemplars of activity, and thus of overall structural organization. One example is of a relatively small structure (i.e. opening interaction), and the other example is of a relatively large one (i.e. dealing with acute medical concerns during primary-care visits).

2.1 The activity of opening

Arguably, the most-investigated conversational activity is that of opening an interaction (for reviews, see Bolden, 2005; Lindstrom, 1994; Luke & Pavlidou, 2002). In a context-free manner, openings are solutions to the problem of how to begin an encounter, and are designed to address important organizational issues for the interaction being begun (Schegloff, 1986). However, the issues vary depending on the nature of interactions, and thus so vary the overall structural organizations of their openings. For example, in many mundane telephone calls between American friends and/or family members (at least before the advent of caller ID), openings canonically involve four ordered sequences of action prior to the initiation of the ‘first topic’ (FT>): summon-answer (1-), identification/recognition (2-), greeting (3-), and How-are-you sequences, which are typically reciprocated (4a- and 4b-). For example, see Extract (1):

(1) Schegloff (1986: 115)

0 1- Ring
1 R: 1- Hello::,
2 C: 2- H'lio, Clara?
3 R: 2- Yeh,
4 C: 3- Hi. Bernie.
5 R: 3- Hi Bernie.
6 C: 4a- How're you.
7 R: 4a- I'm awright,
8 4b- How're you.
9 C: 4b- Okay:?n
10 R: Good.
11 C: FT> Laura there?

In contrast, in primary-care medical visits, openings canonically involve four (roughly) ordered sequences prior to the initiation of the ‘first topic’ (FT>): greeting (1-), securing patients’ identities (2-), retrieving and reviewing patients’ records (3-), and embodying readiness (e.g., sitting down and facing one another; 4-) (Heath, 1981; Robinson, 1998, 1999). For example, see Extract (2). (These data are American, where physicians enter rooms in which patients already reside, which is opposite from the British model.)

(2) Robinson (1999)

1 DOC: 1- Hi.
2 (.
3 DOC: 2- [Mister Bald]win,
4 PAT: 1- [Hello. ]
PAT: 2-> Yes.
DOC: Hi. I'm doct'r Mulad I'm one o' thuh interns here?
(P.
PAT: <Okay,>
DOC: [How are you today.
(((physician closes door))
PAT: Alright,
3-> (1.7) ((physicians reads records))
DOC: *Okay. So. >Can I ask< you ((*=physician sits down))
what brings you in today?
{(./)'/h}
PAT: Yeah. I have lumps, in my uh breasts::.

Compared to ordinary telephone calls ((1) above), in the context of face-to-face primary care medicine, How-are-you? sequences of action, while sometimes present, are not necessary to open interactions, but embodied readiness is (Robinson, 1999; note that, in (2), above, the How are you? issued by the physician at line 11 is not reciprocated by the patient, as it normally is by other parties in ordinary telephone contexts; see Schegloff, 1986). For yet more contrast, the openings of most U.S. telephone calls to 911 emergency services involve only two (interlocking) sequences of action: summons-answer (1->) and identification-recognition (2->). In this context, neither greeting nor How-are-you? sequences of action are necessary to open the interaction (Zimmerman, 1992). For example, see Extract (3):

(3) (ibid.)

1-> ((Ring))
CT: 1-> + 2-> Midcity Emergency::,
2 (.)
C: 2-> + FT> Uh::m yeah (.) somebody just vandalized my car,

While particular opening sequences of action are themselves organized via adjacency-pair sequences (e.g., greeting sequences and How-are-you sequences), the normative existence and ordering of particular sets of actions within openings are products of overall structural organizations. This point was registered by Sacks (1970b: 190, emphasis added):

Then there's this other thing about greetings, having to do with their placing, i.e., that greetings go at the beginning of the beginning section, which is altogether independent of adjacency pair organization and has to do with a different type of organization for conversation, i.e., the overall structural organization. And in those terms there is no information in adjacency pair organization about where the first part of the pair should go in a conversation.

While the expected nature of an interaction (e.g., 911 emergency-service call vs. mundane call between friends) affects the overall structural organization of its opening, it is important to recognize that an interaction’s ‘nature’ is constructed and reconstructed on a turn by turn basis as its opening unfolds. If the nature of an interaction shifts during its opening, so can the overall structural organization of the opening. For instance, in Extract (4), what begins as a call to 911 emergency services ends up as an ‘ordinary’ conversation between friends. Here, C calls D at D’s workplace (i.e., a 911 call center) to ‘chat’.
At line 3, rather than moving to present the reason for the call (which happened in line 3 of (3)), C initiates a greeting sequence, “Hi.” (line 3), which transforms the call into a more ‘ordinary’ form, with the consequence that greetings (lines 3-5) and How-are-you’s (lines 5-7) become relevant (as they were in (1)).

Openings typically conclude with what Schegloff (1986) calls an anchor position, which is typically occupied with the interaction’s ‘first topic,’ often the ‘reason for’ the interaction. This occurs in Extract (1) at line 11, in Extract (2) at line 14, and in Extract (3) at line 3. By virtue of the anchor position, participants and analysts can characterize some topics as ‘official business’ and others as ‘non-official’ or ‘tangential’ matters. When talkables are positioned early relative to the ‘anchor’ position, they can be characterized as ‘preemptive’. There is some evidence, in both ordinary (Schegloff, 1986) and institutional (Robinson, 1999) contexts, that, by virtue of openings’ overall structural organization, ‘preemptive’ topics are understood as relatively important/concerning matters (for one or both interactants). When the ‘reason for’ the interaction is positioned late relative to the ‘anchor’ position, it can be characterized as ‘delayed’ (Bolden, 2005; Schegloff, 1986). Perhaps due to a type of preference organization (that has yet to be fully explicated), there is evidence that ‘delayed’ reasons are sometimes understood as embodying ‘sensitive’ or ‘disaffiliative’ actions (Bolden, 2005).

2.2 The reflexive relationship between activity pattern and production

Activities are the product of interactants’ joint orientation to a supra-sequential “presupposed underlying pattern” (Garfinkel, 1967: 78). As such, activities are types of supra-sequential context that inform the production and understanding of action. A conversation-analytic approach (as described by Heritage, 1984) demonstrates that this pattern/context is not solely a product, for example, of cognitive-based ‘goals,’ ‘scripts,’ or ‘memory organization packets’ (although this may be part of the equation; e.g., Kellerman, et al., 1989). As Drew and Heritage (1992: 19, emphasis added) notes, “the CA perspective embodies a dynamic approach in which ‘context’ is treated as both the project and product of the participants’ own actions and therefore as inherently locally produced and transformable at any moment”. This perspective—which involves conceptualizing activities not as pre-scripted routines, but as ‘achievements’ (Maynard, 1984; Schegloff, 1986)—is not reductionist, and it accords with Garfinkel’s (1967: 78) notion of the documentary method of interpretation, which:

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.

For the first of two examples, consider again the activity of opening primary-care visits (Robinson, 1998). The four opening tasks of greeting, embodying readiness, securing patients’ identities, and retrieving and reviewing patients’ records (see above) are preparatory for dealing with patients’ concerns, and these openings are normatively organized such that these four tasks get accomplished before dealing with patients’ concerns (Robinson, 1999). One consequence of this normative organization is that the exact same physician interrogative format can be understood differently by patients—that is, can accomplish an entirely different action—depending on its location within openings. For instance, when physicians ask the question \textit{How are you? before} they have accomplished the four preparatory tasks, it is \textit{not} typically understood medically (i.e., as a solicitation of patients’ problems), but rather ‘socially’ (i.e., as a solicitation of a patient’s current and general state of being; Sacks, 1975). This can be seen in Extract (2) (above). The patient is visiting for numerous painful and palpable lumps in both of his breasts. After the physician opens the door, he greets the patient (lines 1-4) and confirms his name (lines 3-5). As the physician introduces himself (lines 6-7) he begins to close the door. The physician asks “How are you today.” (line 11) just after closing the door. Although the physician has greeted the patient, confirmed the patient’s name, and introduced himself, he is standing across the room from his desk and chair, and thus has not yet embodied readiness to deal with the patient’s concern. Insofar as the physician has neither sat down nor read the records, he is not sufficiently prepared to deal with the patient’s concerns. Note that the patient responds with “Alright,” (line 13), despite the fact that he is visiting for potentially cancerous lumps (line 18). Thus, arguably by virtue of his orientation to the activity pattern, the patient orients to the physician’s “How are you today.” as a ‘social’ (vs. medical/health) inquiry, that is, as a request for an evaluation of the patient’s current and general state of being (Sacks, 1975) rather than as a solicitation of his medical problems.

In contrast, when physicians ask the question \textit{How are you? after} they have accomplished tasks 1-4, it is typically understood medically, that is, as a solicitation of patients’ medical concerns. See, for example, Extract (5). (These data are British, where patients enter rooms in which physicians already reside, which is opposite from the American model.)

(5) Robinson (1999)

\begin{verbatim}
1 PAT: (Knock Knock Knock)
2 DOC: COME IN.
3 (1.7)
4 DOC: Hello: Come in.
5 (0.6)
6 DOC: Mister Hail?
7 (0.5)
8 PAT: Yes ((gravel voice))
9 (0.2)
10 PAT: Mmmhm ((throat clear))
11 (1.9)
12 DOC: Have a seat
13 (2.4) ((physician reads records; patient sits down))
14 DOC: I’m doctor Masterso[n.
15 PAT: [.h I: believe so.
16 DOC: -> How are you.
\end{verbatim}
PAT: → .hhhhhh I call(ed) down fer som::e=uh::(m) (0.6)

Before the physician produces “How are you.” (line 16), the patient has entered the room and sat down (line 13), and the physician has greeted the patient (line 4), confirmed his name (lines 6-8), read his records (line 13) and introduced himself (line 14). When the physician asks “How are you.”, he is gazing at the patient. At this point, both the physician and the patient have performed the typical preliminary opening actions, and thus have sufficiently prepared for dealing with the patient’s concerns. In response, the patient requests a prescription medication related to urination: I called down for some water tablets (lines 17-18; the patient does not apparently know the name of the medication). In sum, due to its positioning within the activity of opening, the same question, How are you?, accomplishes a very different action. When patients respond differently to How are you?, as they did in Extracts (2) and (5), they (re)document the relevance and nature of the activity of opening a medical visit.

For a second example, consider a different type of medical activity. In a variety of healthcare contexts, providers and clients engage in activities in which providers, across a series of question-answer sequences, gather information in pursuit of particular medical goals, such as developing differential diagnoses (e.g. in pursuit of treating medical problems), documenting medical histories (e.g. in the case of 'wellness visits'), and gathering information for more bureaucratic purposes (e.g. to maintain a nationwide healthcare database). During these activities, physicians engage in practices that (re)document, and patients engage in practices that (re)ratify, individual questions as questions-in-a-series, or elements of a common task. As seen in Extract (6), one physician-sided practice is the contraction of subsequent questions in a process of ellipsis.

(6) Heritage (2010)

1  DOC: 1-> You don’t have as:thma do you,
2   (.)
3  PAT:  Hm mm.
4  (1.1)
5  DOC: 2-> (hhh) .hh Any chest type pain?,
6  PAT:  Mm mm.
7   (3.4)
8  DOC: 3-> Shortness of brea:th,
9   (1.0)
10 PAT:  Some: ...

About this extract, Heritage (2010: 19) observes that:

the first question (line 1) is a fully formed sentence. The second (line 5), by contrast, is shortened to a noun phrase with the negative polarity item ‘any.’ And in the third (line 8), the polarity item is deleted, though its relevance, in part assisted by the etiologic and semantic collocation of ‘chest pain’ with ‘shortness of breath,’ is clearly still in play.

Another physician-sided practice is that of prefacing subsequent questions with and (Heritage & Sorjonen, 1994). For example, all four of the questions in Extract (7) are part of a single data-entry page being completed by a British health-visitor (HV) in plain sight of a new mother.
(7) Heritage (2010)

1 MOM: 1-> So: (.) he's in full time work all the ti:me.
2 HV: "Yeh."
3  (0.4)
4 HV: 2-> And this is y'r first ba:by:.
6  (0.3)
7 HV: 3-> .tch An' you had a no:rmal pre:gnancy.=
8 MOM: =Ye:h.
9  (1.1)
10 HV: 4-> And a normal delivery,

The use of and-prefacing allows questions 2-4, which do not share referential continuity, to be heard as part of a single bureaucratic task initiated by question 1. During the information-gathering activities represented by Extracts (6)-(7), Heritage (ibid.) suggests that one practice by which patients (re)ratify physicians’ individual questions as being in a series of questions is by responding to them in ways that underscore that patients will not continue speaking, such as with “yep” (Extract (7), lines 5 and 11), which is a labial-stopped variant of yes.

To summarize Extracts (2), (5), (6) and (7), participants not only produce and understand action according to a priori activity-related expectations, but they also employ in situ practices designed to get action understood as being activity-related. (Of course, the former—that is, producing actions according to a priori activity-related expectations—is also a practice for (re)documenting activity patterns.) The achieved and negotiated (vs. automated/routine) character of activities is perhaps most exposed when their normative organization is possibly contra-indicated by participants’ actions. We saw this in Extract (4), where a person calling 911 initiates a greeting sequence, “Hi.” (line 3), which works to transform the institutional opening activity into an ‘ordinary’ one.

2.3 Expanding the notion of activity

Overall structural organizations, and thus activities, vary in size and scope. For example, as discussed earlier, the activity of opening is usually composed of a small number of adjacency-paired sequences of action (and, in some cases, sequences of sequences (Schegloff, 2007), as in the case of How are you? sequences), and usually constitutes a very small portion of the entire interaction. However, activities can also be composed of a large number of sequences of action, and even overall structures of sequences of action, and these activities can constitute a majority of an entire interaction. Such mega-activities or mega-structures appear to be more common (or are at least more visible) in institutional (vs. ordinary) interaction, perhaps due to the relevance of institutional goals (Drew & Heritage, 1992). The following section offers one such example.

Robinson (2003) demonstrates that, when adult patients present relatively new (i.e. acute) medical problems to be (re)solved—for example, a new episode of fatigue, muscle aches and fever (i.e. flu), or a new skin lesion—this makes relevant a particular medical project that has its roots in the institutionalized practice of primary-care medicine. This project has an overall structural organization that involves multiple, ordered, medical activities that are ‘properly’ directed by physicians as the relative medical experts. This project has, as its ultimate goal,
treatment of the acute problem. However, physicians cannot effectively treat problems that they have not yet diagnosed. Moreover, arriving at a diagnosis is contingent upon physicians obtaining information about patients’ problems. In sum, the overall structural organization of this project includes multiple components of action and activity, including: (1) patients’ presenting acute medical concerns (almost always in response to physicians’ solicitations of the ‘reason for’ visits, such as *What can I do for you today?*); (2) physicians gathering additional information about such concerns (including history taking and physical examination, typically in that order); (3) physicians delivering diagnoses; and (4) physicians providing treatment. Physicians and patients orient to the project as accountably progressing (Lerner, 1996; Schegloff, 2007) in a directional fashion through these components in order.

Later in this chapter, I discuss the overall structural organization of entire, single episodes of interaction. However, it is important to note that the project currently being described, which is organized around dealing with acute medical concerns, is *not* a relevant feature of all primary-care visits, *per se*. There are ‘types’ of primary care visits different from *acute* ones, such as follow-up visits for a previously diagnosed and treated acute condition, or routine visits for the management of diagnosed chronic conditions (e.g. hypertension, diabetes, etc.). Different types of medical concerns, and the particularities of dealing with them, also make relevant different overall structural organizations of dealing with such concerns (Robinson, 1999). Thus, in the present section, we are dealing with an overall structural organization of a particular ‘reason for visit,’ and *not* with primary-care visits, *per se*. The relevance of this type of overall structural organization is most commonly invoked and endorsed by participants when physicians solicit, and patients present, their chief medical concern. However, just as the ‘nature’ of openings, and thus their overall structural organization, is constructed and reconstructed on a turn-by-turn basis (see (4)), so is the ‘nature’ of the ‘reason for’ primary-care visits. For example, see Extract (8).

(8) Robinson (1999)

1    DOC:  An::d what brings you here to see see us in the clinic?
2  (1.0)
3  PAT:  Well my (.) foot (1.0) uhm (1.0) I was in here on
4  Sunday night=
5    DOC:  =Mkay
6  PAT:  It’s actually a follow up.

The physician solicits the patient’s chief concern with a question format that displays his understanding that the patient has a new/acute concern: “what brings you here...” (line 1; Robinson, 2006). However, the patient ultimately informs the physician: “It’s actually a follow up.” (line 6), which is a different type of reason for visit that makes relevant a different overall structural organization. In the remainder of this section, I provide evidence that participants orient to the proposed medical project as having an overall structural organization, and I provide examples of how that organization is consequential for the production and understanding of action.

**Component 1: Problem Presentation** There is evidence that both patients and physicians orient to problem presentation as in the service of physicians diagnosing and treating presented concerns. For example, see Extract (9).

(9) Beckman & Frankel (1984)
1  DOC: How you been doing?
2   PAT: Oh, well, I been doing okay,

((8 lines omitted))

11  PAT: But lately I’ve been getting this funny, like I’ll
12   lay down on my back, and my heart’ll go “brrr” you
13   know like that. Like it’s skipping a beat or
14   something, and then it’ll just start on back off
15   beating like when I get upset it’ll just start
16   beating boom-bom-bom and it’ll just go back to its
17   normal beat.
18  DOC: Okay.
19  PAT: => Is that normal?
20  DOC: That’s, that’s a lot of things.

At lines 11-17, the patient brings his problem presentation into the present tense (“But lately I’ve been getting...”, line 11) and informs the physician about a currently active acute concern (i.e. heart palpitation), the possible completion of which (at line 17) normally constitutes the possible completion of problem presentation (Robinson & Heritage, 2005). After the physician (merely) claims receipt of the concern with “Okay.” (line 18; Beach, 1995), the patient asks “Is that normal?” (line 19). Here, the patient solicits the physician’s determination of whether or not the problem he presented is actually a problem. The patient’s question displays his orientation to the completion of problem presentation, and the relevance of progressing to a next project component, that being the determination of whether or not he has a problem, which will very likely involve the physician gathering information about that problem. As is the case in Extract (9), and as will be evident in other extracts below, a relatively common source of evidence for the overall structural (or normative) organization of activities emerges at ‘boundaries’ as participants manage the accountability associated with navigating into and out of activities, and from one sub-activity to another (Robinson & Stivers, 2001).

Physicians also orient to problem presentation as being in the service of diagnosis/treatment. For example, see Extract (10).

(10) Robinson (2003)

1  DOC: Uhm,=h Can you tell me what brings you in today?
2   PAT: Yeah my skin’s freakin’ out

((5 lines omitted; unrelated concerns))

8   PAT: ...What I’m concerned about th:ese gu:ys, (0.5)
9   .h (u=they-) startin’ tuh pop oúta my toe:s,
10   (.)
11  PAT: An=uh on=uh back uh my n:èck an’ on my no:se
12  => (ove’ here,) an ah- I don’t know: what- what
13  => [(thuh heck) tuh do ab|out ’em.
14  DOC: => [What they are. [Right.
15 (2.0)
16  DOC: Okay an’ they (ho-) When did it start?
After the patient presents his skin problem (lines 2-12), he claims a lack of knowledge regarding how to treat it, “I don’t know: what- what (thuh heck) tuh do about ‘em.” (lines 12-13), which orients to problem presentation as in the service of treatment. The primary focus, though, is on the fact that, before the patient is projectably complete with his claim (on projectability and completion, see Jefferson, 1984a), the physician attempts to collaboratively complete the patient’s turn (I don’t know what they are) (line 14) (Lerner, 1991; see also Hayashi, this volume). Here, the physician displays his orientation to the patient as presenting his concern in the service of having it diagnosed.

The overall-structural-organization-based norm that patients present acute concerns in the service of having them diagnosed and treated has implications for how problem presentations are designed by patients and understood by physicians. For example, Stivers (2002) demonstrates that patients have at least two different practices for presenting their medical problems, which convey different stances toward the problems’ doctorability (Heritage & Robinson, 2006a) and treatability, and which place differing amounts of pressure on physicians to treat the problems, for example with antibiotics. Relative to the project’s overall structural organization, the first practice is ‘unmarked’ and is one of presenting ‘symptoms only’ (i.e. describing the problem without speculating about a particular diagnosis, which is the purview of physicians). This practice conveys a stance that patients are, first and foremost, seeking the physician’s evaluation (i.e. diagnosis and treatment) of the problem. For example, see Extract (11). Here, in a pediatric context, a mother presents her daughter as having a cough, stuffy nose, and really goopy eyes (lines 3-5).

(11) Stivers (2002)

1  DOC: And so: do- What’s been bothering her.
2         (0.4)
3  MOM: Uh:m she’s had a cou:gh?, and stuffing- stuffy
4  no:se, and then yesterday in the afterno: n she
5  started tuh get #really goopy eye:s, and every=
6  DOC: [Mm hm,
7  MOM: =few minutes [she was ((having tuh-)].
8  DOC: [.hh [Okay so she ha-
9    so when she woke up this morning were her eyes all
10  stuck shut,

The second practice is ‘marked’ and is one of (additionally) presenting a ‘candidate diagnosis,’ which “pushes forward across the physician’s medical judgment by anticipating this judgment” (ibid.: 332) and thereby conveys a stance that the problem warrants treatment. For example, see Extract (12). The pediatrician solicits the mother’s problem presentation (i.e. this is not history taking) with “So how long has she been sick.” (line 1). After presenting symptoms (i.e. “four days” and “headaches”), the mother produces a candidate diagnosis: “So I was thinking she had like uh sinus infection er something.” (lines 10/12).

(12) Stivers (2002)

1  DOC: .hh So how long has she been sick.
2         (1.2)
3  MOM: Just (. ) I came down with it last Wednesday, so
4  she’s probably had it (0.2)
Uh huh.

(Discussion with parent)

MOM: (Like) over—four days?

MOM: An' she's been complaining of headaches.

MOM: So I was thinking she had like uh sinus infection=

DOC: [hhh=er something.=]

DOC: =Not necessarily:, Thuh basic uh: this is uh virus basically:, an' uh: .hh (. ) thuh headache seems tuh be:=uh (0.5) pretty prominent: part of it at fir:st ...

Stivers (2002) illustrates that, during the activity of problem presentation, pediatricians perceive parents' candidate diagnoses as applying ‘pressure’ to prescribe antibiotics, and this is at least partially (if not largely) due to the ‘early’ positioning of diagnoses by patients, which are normally produced by physicians after information-gathering. This can be seen in Extract (12), when the pediatrician disagrees with the patient’s candidate diagnosis, “Not necessarily:,” and then justifies his disagreement by asserting “this is uh virus” (line 13), which is not effectively treated by antibiotics.

Component 2: Information Gathering

There is also evidence that participants orient to information gathering as being done in the service of diagnosis. For example, in Extract (13), the patient is seeing the physician for a sore shoulder. At lines 1-2, the physician asks a history-taking question, which the patient answers at lines 4-7. At line 9, as demonstrated by Robinson and Stivers (2001), the physician begins to transition from history taking to physical examination (which is typically the second sub-phase of information gathering after history taking).

Robinson (1999)

In the transition from history taking to physical examination, the patient provides additional information about her problem by first discounting bursitis as a diagnosis of her problem (line 11: "This is not (. ) bursitis. no:w.=it") and then providing evidence for her claim (lines 11-14: “it doesn’t feel like a bursitis.=an’ it’s not a real sharp pain.=it’s just a .hh an ache, (. ) all thuh tj:me.”). In discounting bursitis as a diagnosis as the physician transitions into physical examination, the patient displays an orientation to physical examination as being in the
service of diagnosis. This analysis is supported by the physician’s response; his “It <might be.>” (line 15), in which the “It” refers to ‘bursitis,’ treats the patient as asserting bursitis as a diagnosis by disagreeing with her assertion.

The overall-structural-organization-based norm that physicians gather information in the service of making a diagnosis, which has implications for treatment recommendations (e.g. the prescription of antibiotics or not), has consequences for how patients understand and respond to physicians’ history-taking questions. For example, in cases where patients’ initial answers potentially undermine the seriousness of a concern, and thus a need for its medical treatment, patients frequently continue to provide information that frames the concern as being serious and in need of treatment (Stivers, 2007). For instance, see Extract (14):

(14) ibid.

As a response to the pediatrician’s question (Q-→), the mother’s initial answer (A-→) potentially undermines the seriousness, and thus treatability, of the concern. After the pediatrician claims receipt of the answer in a fashion that projects movement to a new question (line 4; Beach, 1995), the mother takes the initiative (Robinson, 2001) and adds (using “But...”) a piece of information that is completely outside the frame of the pediatrician’s question (line 5), and that characterizes the problem as nonetheless being serious and in need of treatment.7

Component 3: Diagnosis There is also evidence that participants orient to diagnosis as in the service of treatment. Patients’ orientations tend to emerge when physicians are relevantly delinquent in progressing from diagnosis to treatment. For example, see Extract (15) in which the patient is visiting the physician about a “lump” in her neck. At lines 1 and 3, the physician diagnoses the patient’s problem as a “fatty tumor” (which the physician later claims is not serious and does not need to be treated). Across the next 34 lines of transcript, the physician explains the diagnosis and rules out others, such as arthritis and skin cancer, and does not progress to treatment-related actions. The physician reiterates the diagnosis at lines 38-39.

(15) Robinson (1999)

1  DOC:  This is uh fatty tumor.
2  PAT:  .hhhh Is that what it is?
3  DOC:  (Right.) Uh little fatty tumor.

((34 lines omitted))

38  DOC:  =Yeah this is .h ya know i’=feels like=h uh fatty
tumor.
39  PAT:  Okay. So it- There’s [no-
41  DOC:  [Absolutely
42  DOC:  no{thing to worry about.
43  PAT:  [No need tuh cut it open:, a{n’ (tuh) take it ou:t,
44  DOC:  [No.
After the patient acknowledges and ‘accepts’ the diagnosis with “Okay.” (line 40; Beach, 1995), she asks: "So it- There’s no- No need tuh cut it open; an’ (tuh) take it out,” (lines 40/43). Here, the patient displays her orientation to the relevance of treatment following a diagnosis. The fact that the patient grammatically formats her question so as to prefer a no answer (Sacks, 1987) displays her presumption that at least one form of treatment (i.e. removal) is not necessary. It is possible that this presumption is derived from the fact that the physician has repeatedly reasserted the diagnosis yet not discussed treatment. If so, then the patient, in a sense, holds the physician accountable for not having discussed treatment.

**Component 4: Treatment** When patients present an acute concern as ‘the reason’ for the visit, then the possible completion of the medical project—which, in most cases, is the possible completion of treatment—implicates the possible completion of the business of the visit (Robinson, 1999). Patients orient to this when they, for example, embody readiness to leave offices as physicians complete treatment. For instance, see Extract (16). The patient is visiting the physician to monitor two chronic conditions (diabetes and hypertension) and to deal with one new problem: extremely dry skin. During treatment, the physician fills out a variety of forms (e.g. prescriptions) related to her medical concerns, the last of which is a referral to a dermatologist for her skin problem. The physician projects this to be the last form when he says: “An’ then, (0.9) one more form” (line 724). While the physician fills out the form, the patient tells a story about buying wormy fish at a local supermarket.

(16) Robinson (1999)

```
724  DOC:  An’ then, (0.9) one more form.
725  (0.5)
726  DOC:  For the dermatologist.

((129 lines omitted; patient tells story while physician fills out form))

856  DOC:  .hhh They’ll contact you. uh: with the
857  appointment for the dermatologist.
858  (.)
859  PAT:  ->  Okay.
860  DOC:  Should hear within a couple weeks.
861  PAT:  Alright
862  DOC:  Okay,
863  PAT:  Uh [huh,
864  DOC:  [I’ll see you again in a month.
865  PAT:  Okay.

((6 lines omitted; Physician reminds patient to get sugar test))

872  DOC:  Bye now.
873  PAT:  Bye.
```

Through lines 856-857, the physician visibly completes the form. By proposing a future arrangement regarding treatment, “They’ll contact you. uh: with the appointment for the dermatologist.” (lines 856-857), the physician verbally projects completion with treatment (Robinson, 2001). Through lines 856-857, the patient is sitting in a chair next to the physician’s desk and gazing at the physician, who is sitting at his desk. As the patient accepts the
arrangement, “Okay.” (line 859; Beach, 1995), she shifts her gaze, and thus her current focus of attention, from the physician down to her lap, in which she has her sweater and purse (on gaze, body orientation and attention in medical visits, see Robinson, 1998, for review; see also Rossano, this volume, on gaze in ordinary conversation). Insofar as patients routinely gather their personal belongings in preparation for leaving rooms, a shift in attention to them can display patients’ orientations to the relevance of closing. Indeed, through lines 860-873, the patient gathers her belongings and exits the room.

In sum, overall structural organizations can vary in size and scope, ranging from opening encounters to dealing with acute medical problems. I now expand this scope by examining the overall structural organization of entire, single occasions of interaction.

3 The overall structural organization of entire, single occasions of interaction

This chapter began in a potentially counterintuitive fashion discussing activity. This is counterintuitive because this chapter is about overall structural organization, and in prior CA literature, this term has been virtually exclusively discussed in terms of one particular unit of organization, that being an entire, single occasion of interaction. However, I have noted that many different types of interactional units can have an overall structural organization (Schegloff, 1996, 1998).

Regarding entire, single occasions of interaction, overall structural organization addresses the question: “How does the overall composition of an occasion of interaction get structured, what are those structures, and how does placement in the overall structure inform the construction and understanding of the talk as turns, as sequences, etc.?” (Schegloff, 2007: xiv).

This description was expanded by Schegloff (2010: 133-4):

How do episodes of interaction come into being in the first place, and how are their endings made relevant and consummated … How does the overall structural organization of an occasion of interaction get progressively shaped over the course of its development, and how does placement in the overall structure inform the construction and understanding of the talk as turns, as sequences, and so on? Although not all conversation occurs in structured episodes with discrete boundaries, a great deal does, and there is a distinctive organization of practices that shapes their trajectory.

About the overall structural organization of single occasions of interaction, we know very little more than what was proposed by Sacks (1970a: 157) over 40 years ago, which is that it:

deals, roughly, with beginnings and endings, and how beginnings work to get from beginnings to something else, and how, from something else, endings are gotten to. And also the relationship—if there is one—between beginnings and endings.

Grossly put, virtually all entire, single occasions of interaction – in a generic or context-free sense, that is, occurring in any context between any mix of categories of persons for any reason, including ‘no reason’ (e.g., ‘just to chat’) – are normatively organized as: (1) beginning with an opening (Schegloff, 1986), even if it is minimal, as in calls to 911 (Zimmerman, 1992); (2) ending with a closing (Schegloff & Sacks, 1973); and (3) having ‘something’ in between opening and closing, which I will refer to as topics (Schegloff, 1986). The overall structural organization of entire, single episodes of interaction also includes:
identities for conversation] that operate over distances, i.e., at places that are not directly connected in the conversation, for example, at the beginning of the conversation and at the end. [These are] identities that the conversation itself makes relevant (Sacks, 1971b: 361, emphasis original).

At least one extremely common set of identities is interaction initiator/target (e.g. ‘caller’/‘called’) (Sacks, 1971b), and there appear to be associated identity-bound interactional rights/expectations/obligations, such as initiators producing ‘the reason’ for the interaction (Schegloff, 1986). In many mundane telephone interactions call initiators also initiate call closing (Sacks, 1971b).

Because openings have been discussed above, the following two subsections deal with topics and closings, respectively.

3.1 ‘Something’ in between openings and closings: topics

The ‘something’ in between openings and closings has been referred to as topics (Schegloff & Sacks, 1973), and minimally includes the ‘reason for,’ the interaction, even if that reason is ‘no reason’. 11

Importantly, entire, single episodes of interaction vary dramatically in their contextualized nature. For example, one interaction might be a ‘routine-Sunday-afternoon-catching-up-call-to-Grandma,’ another an ‘anomalous-Sunday-afternoon-request-for-help-call-by-one’s-workplace-supervisor,’ another a ‘public-opinion-survey-solicitation-call,’ and so on. Schegloff and Sacks (1973) talked about the ‘generic’ or ‘context free’ overall structural organization of single episodes of interaction as being necessarily ‘articulated’ with contextual particularities. These ‘particularities’ include “particular speech-exchange systems or classes of them” (Schegloff, 1999: 411), as well as:

- compositional features of the interaction, analysis of relative interactional states of the participants (e.g., involvement in other courses of action of competing priority) and the placement of the conversation in the course of a history of interaction of the parties, and in the interactional occasion on which it occurs (Schegloff & Sacks, 1973: 307).

Although we know little about this process of articulation, one key point of articulation is the overall structural organization of an interaction’s topics, or that ‘something’ in between openings and closings. 12 On the one hand, it is probably the case that interactions in both ordinary and institutional contexts can be pre-organized—from their very beginnings—around one or more topic(s) (e.g. calls to 911 emergency services, or an expected ‘call back’ by a friend to discuss an expected single item of business.) On the other hand, participants can also propose an organization of topics through their composition of the ‘reason for’ the interaction, such as I just called to let you know… (e.g., a single topic), or I wanted to ask you two things… (e.g. two topics). When an interaction is organized around a single topic that is, in turn, organized by a single base-sequence of action, then that topic may or may not be organized by a suprasequential form of overall structural organization—remember, though, that base-sequences of action can have their own form of overall structural organization. However, as discussed earlier, talkables can have this type of overall structural organization, as in the case of primary-care
medicine (i.e. patients presenting concerns and physicians gathering additional information, delivering diagnoses and providing treatment).

3.2 The activity of closing

Like opening, closing is an activity. Participants cannot appropriately terminate occasions of interaction simply by stopping talking and/or walking away (Schegloff & Sacks, 1973). As long as the rules for turn taking are operative, the possible completion of a turn of talk is a place where turn transfer is relevant (ibid.; see also Clayman, this volume, on the transition-relevance place; and Hayashi, this volume, on turn allocation). For this reason the action of stopping talking and/or physically leaving the interaction such as when one person unilaterally ‘hangs up’ or ‘walks out’ on another is accountable—it is considered to be ‘rude’ (Dersely & Wootton, 2000; Schegloff & Sacks, 1973). In order to appropriately close, participants must collaboratively work to suspend the transition relevance of possible turn completion such that stopping talking and/or leaving is understood as ending the occasion and thus not in violation of interactional norms.

A standard solution to the closure problem is a sequence of talk specialized for this particular job, called the terminal sequence (e.g. Bye --> Bye; ibid.). However, there are at least two reasons why terminal sequences are not sufficient to appropriately close occasions of interaction. First, in order to get Bye (or other ‘terminating’ items) heard as proposing termination (as opposed to a range of other interactional ends), participants must establish interactional environments in which proposals of closure can be understood as such (ibid.). Second, at any point during encounters, participants may have additional topics to discuss that have not yet been introduced. The action of proposing closure (e.g. Bye) threatens to interfere with participants’ as-of-yet unspoken agendas and thus infringe upon their rights to produce further talk and topicalize those agendas (ibid.).

The aforementioned insufficiency of the terminal sequence is addressed by the possible-preclosing sequence (e.g. Okay --> Okay). However, given that sequence-initial Okays andAlrights can be used to project shifts of many different kinds (Beach, 1993), these tokens are not necessarily understandable as initiating pre-closing, per se, without themselves being positioned in closing-relevant environments (Robinson, 2001; Schegloff & Sacks, 1973). Closing-relevant environments are largely ascertained by reference to the (overall structural) organization of occasions’ topics, such as the completion of ‘possibly last’ topics. As Schegloff and Sacks (ibid.: 300) argued (paralleling Sacks’ argument about first parts of greeting exchanges within openings; see above): “It does not appear that first parts of terminal exchanges ... are placed by reference to [sequence organization]. Rather, their placement seems to be organized by reference to a properly initiated closing section”, which is organized by reference to the (overall structural) organization of an interaction’s topics. By virtue of this organization, some topics are understandable as being ‘possibly last,’ and their possible completion constitutes closing-relevant environments. For example, in interactions designedly organized around two topics, the possible completion of the second topic constitutes a closing-relevant environment.

4 Future directions
Participants produce and understand social action holistically, simultaneously taking into consideration a variety of types of context, including myriad orders of interactional organization, such as those of word selection, turn taking, repair, preference organization(s), sequence organization(s) and sequential organizations(s) (I have pluralized some of these examples to indicate that they can have multiple incarnations) (Schegloff, 2010). One type of sequential (vs. sequence) organization is overall structural organization. Although it is likely that many different units of interaction—such as turn-constructional units, turns, actions and base adjacency-pair sequences of action—can have overall structural organizations (Schegloff, 1998), this chapter discussed the overall structural organization of more than one base adjacency-pair sequence of action (which is frequently referred to as an activity), as well as of entire, single episodes of interaction (which is, I have argued, essentially another type of activity). Overall structural organization embodies a source of context, and provides a source interactional coherence, that shapes and constrains participants’ production and understanding of behavior in interaction, and that is relatively external to the more local sources provided by, for example, turn and sequence organization. Overall structural organization frequently imposes the onus of progressivity (Lerner, 1996; Schegloff, 2007) through the structure and its components toward completion, and provides the resource of projectability (Sacks, Schegloff & Jefferson, 1974) regarding the completion of the structure and its components. The holistic nature of the production and understanding of social action is usefully analyzed metaphorically as a matryoshka doll (i.e. Russian nested doll), that is, as influenced by multiple, simultaneous orders of interactional organization, with the recognition that those orders are themselves organized relative to each other (Sacks & Schegloff, 1979). All relevant orders reflexively (Heritage, 1984) inform each another, allowing for a type of ‘documentary method of interpretation’ (Garfinkel, 1967), with the recognition that participants are dealing with not one document, but rather a palimpsest.

Much more work needs to be done on how relatively ordinary (vs. institutional) affairs inform, and are informed by, overall structural organizations. One ripe candidate is the overall structural organization of telephone-call topics when the ‘reason for’ the interaction is ‘no particular reason’ (i.e., just to ‘chat,’ or ‘catch up’) (Sacks, 1968c, 1970a). Bolden’s (2005) analysis of ‘late’ personal-state inquiries—that is, ones that are initiated inside an interaction’s closing and that are marked as being ‘late’ with the particle -to (in Russian)—provocatively suggests that at least some ‘no-reason-for-interaction’ interactions are organized around a topical reciprocity of perspectives, where each interactant is ‘due’ a chance to talk about events from his/her own life. If so, in these cases, the possible closure of a first topic by speaker B concerning him/herself (e.g. in response to A’s How are things going?) makes relevant a topic by speaker A concerning themselves (e.g. B then asks: How are things with you?).

Levinson (this volume) reminds us of Sacks’ (1995: 226, emphasis in original) observation that “[a] culture is an apparatus for generating recognizable actions”. Overall structural organizations—which are likely implicated in a wide array of mundane affairs, such as making coffee (Levinson, this volume), changing a baby’s diaper, hosting a dinner party, and so on—are a critical component of culture that has received too little analytic attention.

NOTES
As a unit of interaction, the base-adjacency-pair sequence of action (Schegloff, 2007) organizes the ‘central’ action and, if relevant, its various expansion actions (e.g., pre-, insert-, and post-expansion actions), which are themselves commonly organized by the adjacency-pair sequence. Thus, there is a difference between ‘base’ sequences and ‘expansion’ sequences (On sequence organization, see Stivers, this volume).

I have specifically avoided the conceptual term course of action because it has been inconsistently associated, in prior literature, with multiple distinct concepts, including different types of sequences (ranging from entire base adjacency-pair sequences including their expansions, to single expansion sequences), and what this chapter characterizes as an activity.

For a review of the similarities and differences between openings across cultures, see Lindstrom (1994).

Participants can also design talk in the anchor position to be hearable as not the reason for the call (Bolden, 2005).

If, as I am arguing in this chapter, an activity is essentially a type of overall structural organization, then Robinson’s (1999) reference to components 1-4 as ‘sub-activities’ is potentially misleading. That is, it does not appear that all four components represent activities in the sense of distinct overall structures of sequences of action. For example, component 1, problem presentation, is typically organized around a single sequence of action (Heritage & Robinson, 2006b). However, component 2, information gathering—and especially verbal history taking—is very likely its own activity, that is, a coherent grouping of sequences of action (Boyd & Heritage, 2006).

Components 3 and 4, diagnosis and treatment, are not always realized. For example, in the course of the project, it may turn out that patients do not actually have medical problems to treat, or that patients’ problems are not treatable, or that physicians are not able to diagnose (and thus treat) patients’ problems, and so on. However, because diagnosis and treatment are project-relevant objectives, they are nonetheless oriented to by physicians and patients as relevant, and their nonoccurrence is accountable.

There is evidence that the mother designs her first turn-constructional unit so as to project the second. Specifically, “Not uh let.” (line 3) is a disconfirming nonconforming answer (Raymond, 2003) that may project a type of correction (on repair, see Schegloff, Jefferson & Sacks, 1977; see also Kitzinger, this volume).

First, although I use the term occasion of interaction, recognize that virtually all of this research has involved telephone calls, which is only one type of ‘occasion,’ and thus has significantly shaped our understanding of overall structural organization. Second, I qualify the term ‘occasion’ with ‘of interaction’ to index something beyond a mere exchange of greetings (Schegloff, 1986: 116). As Schegloff and Sacks (1973) note: “Not all conversational activity is bounded and collected into cases of the unit ‘a single conversation.’ That unit, and the structure that characterizes and constitutes it, is therefore not necessarily relevant wherever conversational activity occurs”.

Sacks’ ideas on overall structural organization were influenced by Schegloff’s dissertation (Schegloff, 1967).

Another way of thinking about ‘opening,’ ‘closing,’ and ‘something’ in between is ‘beginning,’ ‘middle,’ and ‘ending,’ which might represent a generic overall structural feature of many different units of interaction, such as turn-constructional units and turns (Schegloff, 1996), actions and sequences (Schegloff, 1998), and activities (Lerner, 1998).

This ‘something’ in between has also been referred to as talkables (Schegloff, 1986). Note that there can be a technical distinction between the relatively external organization of an interaction’s ‘talkables’ and the relatively local organization of ‘topic flow’ in the sense of one topic making some next topics more/less relevant than others (Jefferson, 1984b; Lerner, 1991; Sacks, 1968a, 1968b).

Schegloff and Sacks (1973: 292, emphasis added) alluded to this when they noted: “[W]e are dealing with one aspect of the structure of the unit ‘a single conversation,’ other aspects of which include ... topical structure”.

The intonation contour on tokens such as Okay and Alright also matters for their closing relevance (Bolden, in press).

There are other types of relatively external sources of interactional organization. For example, preference organization, as it applies to sequence-initiating (vs. responding) actions, appears to organize the position and composition of certain base adjacency-pair sequences of action (for review, see Robinson & Bolden, 2010; see also Pomerantz & Heritage, this volume).
References


