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Interaction and Asymmetry in Clinical Discourse[1]

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This article investigates the way in which physicians or clinicians apparently advance their professional dominance by ignoring life-world concerns of the patients or clients they see. Usual analyses of this phenomenon invoke conceptions of authority to explain it implicitly, or they propose that the asymmetry of clinical discourse relies solely on an institutional basis. In order to discover and analyze interactional aspects of the clinical encounter, comparative studies between institutional and everyday contexts are necessary. This article demonstrates that, through the use of a conversational "perspective display series," which is adapted to the clinical environment, a delivery of "bad" diagnosis news can coimplicate the patient's perspective and promote understanding and the appearance of agreement between clinician and patient. In general, describing manifestations of institutional power and authority should include analysis of the ways that participants organize interaction in the first place.

Studies of the doctor-patient relationship uniformly describe an asymmetry of knowledge and authority that allows doctors to promulgate a biomedical model of disease and to simultaneously undermine patients' own experience and understanding. Parsons's (1951) classic study of the doctor-patient relationship, in highlighting the importance of physician control over illness-as-deviance, suggested that asymmetry is functionally necessary to a homeostatic society. Many critics have scored Parsons for overemphasizing the passivity of patients, for ignoring the inherently conflictual situation of doctor-patient interaction, for neglecting broader sociopolitical structures in which the institution of medicine is embedded, and for other shortcomings, but all seem to agree that physicians have

[1] An early version of this paper was presented at the Conference on Talk and Social Structure, University of California, Santa Barbara, March 1986. Later drafts, including the present version, benefited immeasurably from copious oral and written comments by Deirdre Boden, Steven Clayman, Warren Hagstrom, John Heritage, Emanuel Schegloff, and Paul ten Have.

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the power to disseminate medical expertise against and at the expense of lay forms of understanding.[2]

This paper examines communication in one kind of doctor-patient relationship, and its purposes are both substantive and methodological. I argue that asymmetry in the medical interview is not totally a product of the physician's abstract power. Rather than simply being imposed, in other words, asymmetry is interactively achieved. The interactional achievement of social structural features is a core idea in ethnomethodologically derived theorizing and research (Cicourel 1973; Molotch and Boden 1985; Zimmerman and Boden 1991) but, beyond this, I will show that doctor-patient interaction involves *sequences of talk* that have their home in ordinary conversation. Even though the physician's biomedical model takes precedence over patients' own knowledge and understanding of illness, other features of the interaction may be similar to mundane conversational situations. In particular, some clinical deliveries of diagnostic news are similar to how, in ordinary talk, parties organize concertedly to allow one's information and perspective to be expressed seriatim or as the sequel to the other's own displayed view and knowledge. If, at the level of conversational sequencing, we find deep connections between everyday life and the medical encounter, implications for the sociological understanding of clinical and other institutional discourses are vast. Methodologically, it means that strategies of questioning and informing in institutional discourse need to be investigated in relation to the structure of ordinary talk, especially its sequential organization. Theoretically, this may show that asymmetry and other features of clinical discourse, rather than flowing solely from the imposition of institutional authority, derive partly from participants' indigenous resolution of interactive problems that transcend the doctor-patient dialogue.

The paper begins by showing a phenomenon of asymmetry—the promotion of the biomedical model as opposed to lay experience and understandings—in one type of medical encounter. Next is a review of various conventional explanations for the phenomenon, followed by an analysis of a *perspective-display series* (PDS) that conversationalists employ in trading information and opinions on ordinary social objects. This organized series of turns is adapted for use in clinical discourse, and I analyze how it operates for the delivery of diagnostic news. Finally, this permits detailed comparison of doctor-patient communication and ordinary interaction, which, in general, leads to fuller sociological understanding of the prominent features of institutional discourse.

[2] The literature on doctor-patient interaction is vast. Particularly useful reviews can be found in Anspach (1988), Bloom and Wilson (1979), Fisher (1986), Jensen (1986), Mishler (1984, chap. 2), West (1984*b*, chap. 2), and West and Frankel (1991). On the particular topic of asymmetry, see Heath (in press) and ten Have (1991).

THE DATA AND PHENOMENON FOR STUDY

The data for this study differ slightly from the prototype (but see Parsons 1951, pp. 446–47). The patients are children who have been referred to a clinic for developmental disabilities. This clinic performs diagnostic services, such as giving neurological, psychological, and intelligence examinations. Pediatricians, social workers, educational psychologists, speech pathologists, psychiatrists, and other professionals may all view the child and family. When the clinicians have completed their examinations and have arrived at a diagnosis, they must present it not to the child, but to the child's representatives or agents, the parents (cf. Silverman 1981; Strong 1979). This is done during an "informing interview." The complete corpus of data includes over 50 such interviews between clinicians and parents.[3]

The phenomenon of analytic interest, in general terms, is the apparent suppression of patient or client experience in favor of a clinical perspective. The prototypical example is of a patient who arrives at a doctor's office and presents a complaint. The doctor, largely by way of questioning strategies that require delimited responses, works the complaint into biomedical categories that lack sensitivity to the patient's psychosocial concerns, life world, and folk understandings. In my data, the phenomenon of asymmetry takes the form of clinicians' suppressing parental experience related to their children's symptoms rather than the parents' own. To fully display the phenomenon, I will examine a single interview wherein a pediatrician asks the parents how they see their child, listens to their responses, and proceeds to deliver clinical information in a way that seems to deal marginally with the concerns and opinions the parents expressed in answering her initial question. Scrutiny of the entire corpus of data reveals that this is a characteristic and not idiosyncratic phenomenon, most especially and paradoxically when clinicians directly ask parents for their view of the child being diagnosed.

The opening portion of a single interview is being used as a vehicle for this discussion (see "Transcript of Informing Interview" in the Appendix). Later analyses are based on all instances in the corpus. The transcript in the Appendix can be loosely divided into three sections, which will later be identified as corresponding to parts of a "perspective-display series." The pediatrician ("Dr" on the transcript) asks the parents (lines 2–3) how they "see" J, their daughter, "at this time." The

[3] The data were collected under grant HD 01799 from the National Institutes of Health, Stephan A. Richardson, principal investigator, and grant HD 17803-02, Douglas W. Maynard, principal investigator. Bonnie Svarstad, who worked on the former grant with Helen Levens Lipton, with permission generously made the Richardson data available to me.

parents ("Mo" and "Fa" on the transcript) then present their view of J (lines 4–121). Finally, the pediatrician presents the clinical diagnosis (lines 122–56). Starting at line 123, she reports on the "psychological testing" and tells the parents that J's intelligence is normal, but that she has "a very specific problem with language" (lines 144, 147).

I start with a traditional format for analyzing this transcript (which comprises the overwhelming bulk of the informing interview), characterizing it ethnographically by breaking it down further into 13 question-initiated segments. I identify these segments according to a three-part unit that Mishler (1984) and others describe as relevant to doctor-patient interaction: (1) question, (2) reply, (3) response. The first segment contains the pediatrician's global query ("How do you see J at this time?"). The parents reply by referring to J's speech and pronunciation difficulties. In subsequent segments, the doctor probes the parents for further displays of their perspective, and a variety of topics concerning the child emerge. In table 1, I list the 13 segments and their questions, replies, and responses. Between the parents' replies and the doctor's responses, I interpose ethnographic, summary "glosses" of the parents' replies, describing their comments as "diagnoses," "theories," "evidence," and so on. The interest here is in how, after the clinician asks the parents for their view of J, and after they display their views, she then responds to these displays.

Briefly, of all the things the parents produce, only a few are consequential to the clinician's responses. Thus, the pediatrician does take up the parents' concern about J being unclear and perhaps underdeveloped in speech (see segment 3 in table 1) by probing them further (segment 4). She similarly deals with the mother's diagnosis of "not normal" by asking for examples (segments 5, 6). Slightly later, the doctor attends to a quoted characterization of things taking "longer" for J to "learn" by asking "why" this might be (segments 7, 8). Next, after Mrs. C, the mother, replies that others have suggested J is retarded (segment 8), the clinician asks if this is her own worry (segments 9, 10). Mrs. C disconfirms this by saying J is "just slow in learning" (segment 10), and then the pediatrician, querying about the extent of the slowness (segments 11 and 12), pursues this topic. Notice that when the doctor (Dr. S) moves to present clinical findings and diagnoses (starting at line 123 in the Appendix), she states that J is "at the lower end . . . of normal intelligence" (line 127) and that she "does not appear to be a retarded child" (line 130). It seems, therefore, that her probing in regard to J's speech difficulty and its causes enables the clinician to see what the parents' position is and to deliver clinical findings that confirm the parents' sense that the child is just "slow" and not "retarded."

If the pediatrician does speak to the parents' concern about J's speech

TABLE 1

SUMMARY OF DOCTOR-PATIENT INFORMING INTERVIEW

Segment	Doctor's Question	Parent's Reply	Reply Gloss	Doctor's Response
1	Now that you've-we've been through all this I'd just like to know from YOU how you see J at this time (lines 2–3)	The same, she can't talk, she can't speak . . . clearly, she can't pronounce words (lines 5, 9–14)	*Parent's diagnosis:* J has a talking or speaking problem	"Mm h" (line 18)
2	(refer to question above)	She talk like the other kids, like babies, she try to imitate them so maybe she attract more attention, so she tries to act the same way you know (lines 19, 22, 26–30, 32)	*Father's theory:* J tries to attract attention by acting like a baby	Minimal utterances ("mm hmm"), silences (lines 21, 24–25, 31, 33), and then question about other children's ages (line 34)
3	Does the 3-year-old talk better than J? (lines 39, 41)	Yes, clearer (lines 42–44)	*Parent's diagnosis:* J's language development is behind	Probing question about how J was earlier "progressing" (lines 47–50)
4	When J was little, she still wasn't progressing the way she should? (lines 47–50)	No, she use to do things that weren't normal at all (lines 49, 51)	*Parent's diagnosis of earlier behavior:* not normal	Asks for examples (line 53)
5	Like what? (line 53)	She use to lick the floor when we used to tell her not to do that (lines 54–5)	*Mother's complaint:* licking the floor	Minimal utterance ("mm hmm," line 56)
6	(refer to question above)	My mother . . . use to say it use ta take longer with her to learn things	*Mother's report of her mother's diagnosis:* takes J longer to learn things	Query as to why (line 63, in overlap with father)
7	Why do you think that this is? (line 63)	Were told that she was spoiled by her grandmother (line 68 ff.)	*Father's report of grandmother's theory:* J was spoiled	Dr's response: None

8	(refer to question above)	Took her to friend's house and she's a nurse and she told me that girl don't look like she's normal, and everybody used to tell me the same thing like she was retarded or something (lines 69–72)	*Mother's report of other people's offered diagnoses:* J is not normal, J is retarded. (This disagrees with father's report above)	Queries as to whether the retardation issue is a worry (lines 73–74)
9	Is this something that you were worried about, that she might be retarded, and that might be the reason for the language problem? (lines 73–4)	I can't worry about it, I have to live with that, I can't worry (lines 76–79)	*Father's denial of worry*	Restates her question as to whether they think that retardation might be the reason for the talking problem (lines 81–83)
10	Is this [retardation] something in the back of your mind, that maybe that was the reason why she isn't talking? (lines 81–83)	(Mother:) I don't think so, I think she just slow in learning (line 85) (Father affiliates with this, line 87)	*Mother's diagnosis:* slow in learning	Queries as to whether this is in everything or just some things (lines 88–90)
11	Is she slow in learning everything or there's some things she can learn very quickly, pick up on? (lines 88–90)	(Mother:) Yes, she watches Sesame Street and she knows some of the ABC's, and to count, she doesn't know how to count (lines 94–97). (Father:) What if she might be absent minded? (line 98)	*Mother's evidence for her diagnosis:* knows some ABC's but not how to count; *Father's theory:* absentmindedness	Ignores father by interrupting him, queries about the 2-year-old
12	And the 2-year-old? (line 99)	He's smarter than her	*Mother's evidence for her diagnosis:* comparison to brother	Minimal: asks about other activities
13	What about doing things like helping you around the house, setting the table, or dusting? (lines 104–7) Playing with blocks or crayons on the wall? (line 112)	(Mother:) No, she doesn't play with that she breaks them (lines 108, 111, 113, 115). (Father:) She plays with crayons on the wall (line 114)	*Mother's and father's complaints:* she doesn't help, she breaks things, she colors on the wall	Queries about whether she does not use crayons on paper (line 118), and then moves to deliver clinical findings and diagnoses (lines 123–56)

development, she does not actively pursue or sometimes even acknowledge a number of other matters. These include the parents' diagnosis that J cannot talk or speak clearly (segment 1),[4] their complaints about J's behavior, such as licking the floor (segment 5), breaking things, and coloring on the wall (segment 13), and the father's theories regarding how J tries to attract attention (segment 2) or might be absentminded (segment 11). Other matters that appear inconsequential for the clinician, at least in the talk here, are at a slightly more complex level because they are embedded in discussions of other things rather than themselves being a focus. These matters include how the grandmother(s) (segments 6 and 7), Mrs. C's friend, and "everybody" (segment 8) react to J, and the possibly troubled relations between the parents and these others that such reactions may produce or exhibit. There is also each parent's own view; the two may not be of one mind regarding J's problems. The father seems to theorize that J is a malingerer (segments 2, 7, and 11), while the mother, who offers more concrete observations regarding J's development and behavior, never affiliates with the theoretical viewpoint of the father. In fact, as the parents answer Dr. S's questions, at one point (segments 7, 8) there is an apparent display of disagreement. The father suggests that J is spoiled, while the mother offers that she is "not normal" and reports others' opinions that she is retarded.

Conventional Explanations of Asymmetry

During conferences or examinations, in general, doctors may ask patients (or their representatives) for their view of a problem or illness and yet disregard much of what then gets said. Discrepancies between patients' or parents' perspectives and those of clinicians or practitioners, together with the triumph of a biomedical model, are documented throughout medical sociology. For sake of simplicity, I will collapse conventional explanations of the asymmetry phenomenon into three types, ranging from the "macro" to the "micro" level, making brief references to works that may overlap, and whose complexities cannot receive justice here. It is the remarkable consistency of extant studies that I wish to highlight through the following discussion.

[4] Later, the clinician clearly states that J has a problem with "language," which to her at least is different from the parents' reference to J's talking and speaking difficulties. At the end of the interview, when it is clear that the parents do not understand the distinction, Dr. S explains, "Language are [*sic*] the actual words. Speech is how the words sound. Okay? J's speech is a very secondary consideration. It's the language which is her problem. When language goes into her brain, it gets garbled up, and doesn't make sense. . . . It has something to do with the parts of her brain that control speech, that control language, and it doesn't work."

Professional authority.—Lay persons may confront communication difficulties with doctors because the latter have command of cultural authority through which they "judge the experience and needs of clients" and construct medical reality (Starr 1982, p. 13). Such authority derives in part from the development, in the last century, of sophisticated diagnostic technology, concomitant specialization, and peer-validated professional competence. Although being more historically sensitive, Starr (1982) nevertheless reinforces Parsons's (1951) original statement that professional authority is based on access to those valued goods and services that patients need. It also accords with Freidson (1970) who, unlike Parsons, emphasizes conflict between patients and doctors but who sees its resolution as flowing from this same feature of the doctor-patient relationship. That is, patients acquiesce to the physician's perspective and advice, whether they agree with it or not, because of the physician's gatekeeping monopoly over such matters as therapy, surgery, prescriptions, insurance, and sick leave (Freidson 1970, pp. 116–17).

Sociopolitical structures.—From a more critical perspective, the phenomenon of asymmetry in the medical interview is not just a matter of professional authority. Rather, it is an aspect of medicine's place in the exploitative class relations characteristic of contemporary capitalism (Navarro 1976). The discourse of the medical interview reproduces patterns of domination and subordination by legitimating class relationships, administering information, and using science as a mode of ideology to obfuscate exploitation (Waitzkin 1979; Waitzkin and Stoeckle 1976). For example, doctors reinforce oppressive arrangements in work, family, recreational, and other aspects of social life (Waitzkin 1983, p. 180) and help to individualize the origins of social problems (see Conrad and Schneider 1980).

In this view, physicians are agents of social control, operating on behalf of the capitalist class. In a different critical analysis, Foucault (1972) argues that physicians are, as much as the patients they treat, subject to the control of discursive formations or anonymous "unities" that operate on all individuals who speak within a given field (see Dreyfus and Rabinow 1982, p. 61). The asymmetry in clinical discourse occurs because the technology of domination requires the physician-as-facilitator to awaken even the subjectivity of the patient to be captured by pervasive forms of knowledge and power in which both parties are embedded. "Everything," say Arney and Bergen (1984, p. 170), "no matter how trivial it might seem, must be noted, recorded, and made the object of analysis." Moreover, the technologies of monitoring and surveillance are reaching more and more into everyday life (Foucault 1972; Dreyfus and Rabinow 1982, p. 48; Arney and Bergen 1984, p. 166). Thus, instead of physicians acting as agents of institutional arrangements that rob patients

of their lives and autonomy, the distinction between institutional and everyday experience is collapsed as both parties to the medical transaction become tangled in the all-encompassing web of discursive formations.

Communicational structures.—Scholarly work that analyzes doctor-patient interaction in terms of authority relationships or of larger sociopolitical structures treats communication, to paraphrase West (1984*b*, p. 34), as a "by-product" of such relationships and structures. By contrast, those who study the communication process argue that it is the very means by which participants enact patterns of authority, distinctions of class, discursive formations, and other institutional features that form the social surround. Thus, through interview and observation, cognitively oriented sociologists and anthropologists have uncovered discrete manifestations of conflict in the medical interview. As patients move from home and community to formal health care systems, Kleinman (1980, p. 99) argues, they develop and employ cognitive value orientations that embody personal and community meanings. In the clinic, patients meet the practitioners of biomedicine who use impersonal, objective, and scientific frameworks, and this results in frequent problems of communication that may even interfere with the adequacy of health care.

The confrontation between divergent values and orientations is resolved, Cicourel (1982, p. 72) suggests, because of patients' "compliance with the physician's speech acts" and the resultant transformation of locally based accounts into institutionalized categories of disease (Cicourel 1981; cf. Smith 1987). Indeed, interaction-oriented researchers point to the linguistic and interactive ways in which the phenomenon of asymmetry is exhibited. Doctors ask more questions than patients (Frankel 1989; West 1984*b*), interrupt patients more than the reverse (West 1984*a*, 1984*b*), control topical development (Beckman and Frankel 1984; K. Davis 1988), define patients in gender-stereotypical terms in such a way as to make unwarranted assumptions about their needs and symptoms (Fisher 1985; Todd 1989), and so on (see also Byrne and Long 1976; Fisher 1984a, 1984b; Strong 1979; ten Have, 1991.[5] In Mishler's (1984) analysis, physicians use the "voice of medicine," which expresses the scientific attitude and insists on technical interests in suppressing patients' "voice of the lifeworld," which represents their biographical and real-world concerns (see Silverman and Torode 1980). That is, through

[5] Note that most of these accounts emphasize what physicians "do" to patients, although see West (1984*a*) for an example of how some patients (male) interrupt some physicians (female). In Heath's (in press) study, asymmetry is embodied in identifiable sequential and interactional mechanisms. For example, after a physician provides an assessment, patients often withhold any reply and thereby contribute to preserving the objective and scientific status of the diagnosis.

the request-response-assessment structure that characterizes the medical interview, physicians decide when patients can take a turn, selectively attend to technically relevant aspects of patients' answers, and ignore the life context of the symptoms patients present. The patient's "voice" is ultimately stifled and silenced as the clinician asserts and reasserts the "dominance and singularity of the clinical perspective" (Mishler 1984, p. 83).

Summary.—The present study is continuous with other microanalytic research in arguing that physician control of the medical interview, although predictable, is no automatic effect of institutional pressures (ten Have 1991). Parties to the interview constitute and enact the asymmetry in clinical discourse and thereby produce and reproduce the features of social structure (e.g., Cicourel 1973; Zimmerman and Boden 1991). Still, because prior cognitive and linguistic studies share an assumption with studies of the authority, sociopolitics, and discursive formations of medicine, there is an avenue of departure in the present research. That is, macro-level and mid-level theorizing about doctor-patient interaction, with its emphasis on professional authority and sociopolitics, proposes either a radical disjunction between everyday life and clinical discourse, or else sees discourse as coming to supplant everyday language. Similarly, microanalytic theory and research, as ten Have (1991) has pointed out, assume a model of symmetrical interaction in ordinary conversation and document an almost absolute imbalance of control and authority in the communicational structures of medical discourse. It is as if there is no room and no time in the medical interview for accomplishing other features, particularly those that are characteristic of ordinary talk as an interactional domain organized independently of institutions and discursive formations that could subsume it. In short, along with their macro-level counterparts, microanalytic investigations of clinics, in concentrating on ways in which participants "do the institution," may have neglected how they "do the interaction."

It is not that conventional accounts of the phenomenon are wrong. Rather, they pose an external basis for ordinary features of interaction that are endogenously produced in the very details of concerted behavior (Garfinkel 1988). Stated differently, premature invocation of the institutional order to explain face-to-face phenomena can obviate an appreciation of that social organization which occurs as an indigenous and real-time accomplishment of participants using the procedures of talk-in-interaction (Schegloff 1987). Even in clinical or other institutional discourses, there is an interactional order whose operation is relatively independent of the social surround as it is theoretically or abstractly characterized. To understand what is occurring interactionally in discourse, and as one means for gaining access to what might be the primor-

dial sites for the analysis of structures of everyday life, comparative studies are required.[6] Moreover, by first exploring the interactional basis of institutional discourse, it may be possible to better explicate just how power and authority are manifested within it.[7]

THE PERSPECTIVE-DISPLAY SERIES IN ORDINARY CONVERSATION

In ordinary conversation, as in clinical discourse, when one party has an opinion or assessment to give, there are different strategies for doing so. One strategy, sometimes warranted by current participation in an assessable event, other times by narrating past participation in such an event, is to *offer* an opinion (Pomerantz 1984*a*). The perspective-display series (hereafter, PDS) is another strategy; through it, one party solicits another party's opinion and then produces a report or assessment in a way that takes the other's into account.[8] It appears that such reports can be like "news announcements," operating as topical talk and providing for at least some "receipt" of the report or possibly a "topicalizer" in the next turn (Button and Casey 1985, p. 25). However, the key feature of a PDS is that the report is preceded by the recipient's solicited display of perspective. In excerpt 1, turn (1) is an opinion query or perspective-display invitation, (2) the reply, (3) the asker's own report. Subsequent to the third-turn report, Al provides (4), topicalizers (lines 6, 9), that occasion Bob's elaboration on the report (lines 7–8, 10–11; excerpts have identifying transcript locations in parentheses).

[6] For general statements on this point, see Heritage (1984), Schegloff (1980), and Zimmerman and Boden (1991) and for previous comparative empirical work, see Atkinson and Drew (1979), Clayman (1989), Heritage and Greatbatch (1991), ten Have (1989), and Whalen and Zimmerman (1987).

[7] In what follows, I distinguish two arenas of linguistic interaction by referring to (*a*) talk in everyday settings as "conversation" and (*b*) that in institutional settings as "discourse." While this distinction is rough, it is a useful heuristic for pointing the way toward an empirically grounded, technical specification of the structure of talk in institutional settings. For a lucid discussion of the difficulties of separating ordinary talk from discourse in a scientific laboratory, see Lynch (1985, chap. 5).

[8] The perspective-display series has been explored at length in both clinical discourse (Maynard, 1991*b*, in press) and ordinary conversation (Maynard 1989*a*). Here, I present results in summary fashion and simply assert some things that have been established analytically in the other papers. Rather than make reference to these other papers on a point-by-point basis, I would ask readers to consult these other papers for explication of any particular assertions that receive only brief attention here. These other papers analyze all instances of the perspective-display series in several collections of data.

Excerpt 1 (22/2.275)

1 → 1.	Bob:	Have you ever heard anything about wire wheels?
2 → 2.	Al:	They can be a real pain. They you know they go outta line
3.		and—
3 → 4.	Bob:	Yeah the— if ya get a flat you hafta take it to a special
→ 5.		place ta get the flat repaired.
4 → 6.	Al:	Uh— why's that?
7.	Bob:	'Cause um they're really easy to break. I mean to bend and
8.		damage.
→ 9.	Al:	Oh really?
10.	Bob:	An' (.) mos' people won' touch 'em unless they 'ave the special
11.		you know equipment or they— they have the know how
12.	Al:	They're like about two hundred bucks apiece or something too.
14.	Bob:	Yeah, ya get 'em— you get 'em chromed and that's the only way
15.		to have 'em just about too you know
16.	Al:	heh Yeah

The first two turns are similar to what Sacks (1966) has called a presequence. Presequences include the summons-answer type, by which participants provide for coordinated entry into a conversation (Schegloff 1968); preinvitations ("Are you busy Friday night?"), by which a speaker can determine whether to solicit someone's coparticipation in a social activity (Sacks 1966); preannouncements ("Have you heard?"), through which a speaker can discover whether some news to be told is already known by a recipient (Terasaki 1976). Depending on what a speaker finds out by initiating a presequence, the conversation, invitation, or announcement may or may not ensue. Here, as with presequences in general, the perspective-display invitation and its reply seem to have alternative trajectories. Sometimes, the reply to a perspective-display invitation will be followed by further questions or other topicalizers that permit the recipient to talk at length on some topic. The questioner, never announcing any independent information or perspective, appears to "interview" a recipient and provide for that person to do extended topical talk. At other times, as in the above example, the asker follows a reply with his own report or with further questions and then with his report.[9] We will return to these points; for now, I will refer to the PDS

[9] To be technically clear: in terms of the organization of sequences, the first two turns of the perspective-display series comprise a presequence (as noted). The third-turn report of the PDS is akin to a "news announcement" (Button and Casey 1985), providing for at least some "receipt" of the report or possibly a "topicalizer" in the next turn; this occasions elaboration of the topic. Thus, turn three of the PDS is turn one of a news announcement sequence, the latter being prefaced by a presequence.

perspective-display series	sequential organization
turn 1 (PD invitation)	presequence turn 1 (question)
turn 2 (reply)	presequence turn 2 (answer)
turn 3 (report)	topical turn 1 (announcement)
turn 4 (topicalizer)	topical turn 2 (topicalizer)

After the topicalizer, a speaker can elaborate on the report or announcement.

as consisting of the first three turns listed above. The interrelations among these turns are the focus of my analysis.

A search through a variety of conversational collections turned up fewer instances of this series among *acquainted* than among *unacquainted* parties. It may be that the circuitous way in which the PDS allows arrival at a third-turn "report" is an inherently cautious maneuver that makes the series particularly adaptable to environments of professional-lay interaction, conversations among unacquainted parties, and so on. One issue with which the PDS seems to deal is the knowledge or understanding that the potential recipient of a report can be expected to show. Notice in excerpt 1 that Bob's initial query, asking Al whether he "has heard anything about wire wheels," is formatted as an inquiry into Al's knowledge base. More than that, the series enables a speaker to discover how a mentionable report or opinion will fit with recipient's attitude; if the fit is good, the speaker can anticipate that the report will occasion a display of affiliation. Thus, after Al's assessment that wire wheels "can be a real pain," and the start of a listing that would warrant such an opinion, Bob's report continues the listing and seems consistent with the assessment. Then, subsequent to Bob's elaboration, Al produces what is hearable as a complaint about the price of wire wheels (line 12) and thus aligns with the negative assessments so far proffered. In general, the PDS allows a report to be delivered in a hospitable environment and in a way that *coimplicates* the recipient's perspective.

Marked and Unmarked Queries

The first turn in the series, consisting of an invitation or opinion query, elicits in the second turn an assessment from the coparticipant. Assessments can consist of (*a*) praising and complimenting terms, (*b*) complaints and expressions of concern, and so on. Perspective-display invitations may exhibit an expectation that the subsequent assessment will be positive or negative (cf. Sacks 1987, p. 57). Thusly, they are questions of the type that Pomerantz (1988) has called "offering a candidate answer," providing a speaker's "best guess" as to what recipient will reply. For instance, some invitations are marked to expect a complimentary assessment:

Excerpt 2 (13/9.208)
→ Carrie: Ya like it up here though?
Abby: Yeah! I really do.

Excerpt 3 (9/20.88)
→ Sharon: Do you— um LIKE the dorms?
Sheila: Yeah. I like them pretty much.

Excerpt 4 (16/8.52)

→ Alice: San Rafael's— is that really nice? I mean,
Jane: Uh huh
→ Alice: do you really like living there?
Jane: Yeah I lived in Santa Cruz last year.

Thus, elicited positive assessments may simply ratify what is proposed in a marked perspective-display invitation. Compared with positively marked queries, negatively marked ones are rare. They become warranted because of previous topical talk:

Excerpt 5 (19/8.180)

1. Alice: What sports do you plAY?
2. Jane: Well that was BASketball. But I quit.
→ 3. Alice: Oh. Oh yeah? Didn't like it?
4. Jane: Uh— I didn' like the coach.

Alice's announcement (line 2) that she quit basketball provides for the relevance of an account, which is elicited through a negatively framed perspective-display invitation at line 3. Besides positively and negatively marked queries, others are unmarked or neutral in terms of explicit expectation. Excerpt 6 is an instance:

Excerpt 6 (2/15.92)

→ John: So what do you think about the bicycles on campus?
Judy: I think they're terrible.
John: Sure is about a MILLION of 'em.
Judy: eh heh

Note here that the neutral invitation does obtain a complaint or negative assessment as a reply. The rarity of negatively marked opinion queries and the use of immediate conversational contexts for warranting them suggest that eliciting a negative assessment is problematic in a way that eliciting a positive assessment is not.[10] Use of the neutral query, therefore, may be a way to occasion the display of a negative assessment without doing so officially. In any case, parties infrequently show an expectation that someone else has a negative opinion and are not so reluctant in regard to positive opinions.

The Preference for Agreement and the Use of "Probes"

No matter which kind of utterance starts it off, the PDS represents a cautious way of putting reports, opinions, and assessments on the floor.

[10] Evidence for the delicacy of producing negative assessments can be seen in Button and Casey's (1985, p. 38) discussion of topical talk. Conversing with another, one party who has "adverse comments" about a mutual friend can manage talk such that these comments are requested by the other rather than volunteered.

This caution may relate to the preference for agreement in conversation, which concerns structured or institutionalized aspects of conversational activities, not the coparticipants' attitudes or psychologies (see Heritage 1984, p. 267; Schegloff 1988). For instance, Pomerantz (1984*a*) has shown that following one party's production of an assessment, another party will produce a "second" assessment in different ways depending on whether it agrees or disagrees with the first. Agreements are done immediately (with no preceding silence or prefacing talk), are stated forthrightly, and occupy entire turns, while disagreements are delayed through pauses and prefaces (including agreement components), are mitigated, and usually form only part of a full turn of talk.

Participants may enact a preference for agreement through the PDS in several ways. For one, if an asker potentially disagrees with what the recipient says, it provides the asker with the option of withholding any then-and-there display of disagreement. This can be inferred from the organization of presequences. That is, as precedent to some focal activity to which they relate, presequences elicit material that is relevant to deciding whether to pursue the focal activity. Hypothetically, by asking another's opinion, and discovering that opinion to disagree with one's own, one can omit producing a third-turn report. Furthermore, when the recipient of an invitation gives neutral or even resistive replies, these replies can nonetheless be exploited to suggest affiliation between the two parties' perspectives. In one example, a woman, Bev, asks her friend Lyn what she "thinks" about a mutual acquaintance who is "getting all this publicity" in the local newspaper. While Lyn avoids giving a direct opinion, and shows other signs of resistance to an analyzable trajectory in Bev's talk, Bev nonetheless suggests, in her third-turn report, that her recipient "picked up" (and thus understands or possibly even approves of) her own concern about the acquaintance (Maynard 1989*a*, pp. 101–3). Relative to her own position, Bev thus "reads" her recipient's neutral replies in an affirmative fashion. Finally, if an asker does discover a perspective on the part of a recipient with which a third-turn report will disagree, the display of disagreement is mitigated:

Excerpt 7 (8.33)

1 →	1.	Jane:	How da ya like the class
2 →	2.	Alice:	Um tch I don't know, it's like— I like his lectures an' stuff
→	3.		but— you know, sometimes I can get into 'em but like— you
→	4.		know some of the things I have difficulty relating. You know?
	5.	Jane:	Yeah?
→	6.	Alice:	Like you know, jus' the stuff about— like the George Herbert
→	7.		Mead jazz an' stuff an'
	8.	Jane:	The what?
	9.	Alice:	The George Herbert Mead stuff?
	10.	Jane:	Oh Mead

	11.	Alice:	And— yeah.
3 →	12.	Jane:	Yeah I don't know, I— I can get IN that pretty much.
	13.	Alice:	Um, I don't know heh
	14.	Jane:	So what's your name?

Here, Alice starts her answer to the opinion query with a disclaimer of knowledge ("I don't know," line 2). Jane uses the same disclaimer to precede and thereby delay her report (line 12), and Alice repeats the disclaimer as a receipt of that report (line 13). In short, the parties collaborate in avoiding the stark display of disagreement that their contrastive positions imply (note that at line 14, Jane introduces a topic change).

The preference for agreement, then, shows up in the way that participants handle potential and actual disparities of opinion. On the other hand, if an asker's report in any way fits favorably with a recipient's displayed perspective, then the asker regularly expresses agreement (with a "yeah" token) and/or produces the report immediately (see excerpt 1 above). One last matter is that if a recipient's answer is ambiguous or not clearly in agreement or disagreement with what a speaker has to say, then the speaker can *probe* the recipient to obtain material with which agreement can be fashioned. In the next example, after an initial opinion query (line 5) and its ambiguous answer (line 6),[11] the inviter proposes an assessment (line 7; arrowed with a "P" for "probe"), and then follows the reply (line 8; arrowed with a "PR" for "probe reply") with an announcement (lines 9, 11) for which the elicited evaluation stands as an account. Thus, Lisa ends up agreeing with Jenny's assessment.

Excerpt 8 (1/11.173)

	1.	Lisa:	Is this your first year here?
	2.	Jenny:	Mm hmm. Yeah.
	3.	Lisa:	Did you go to J.C.?
	4.	Jenny:	No, I went to San Diego State
1 →	5.	Lisa:	Oh. Ya like it?
2 →	6.	Jenny:	Hm un.
P →	7.	Lisa:	You di—it was a lot EAsier than here wasn't it?
PR →	8.	Jenny:	So much easier.
3 →	9.	Lisa:	Yeah, god I have some friends down there. gahhh!
	10.	Jenny:	It's so much easier
→	11.	Lisa:	They NEVer STUDY! I'm jealous heh heh! ehh
	12.	Jenny:	Um hmm

And in excerpt 9, after Carrie's marked invitation about liking it "here" (line 1) and Abby's affirmative reply (line 2), Carrie asks her recipient to account for being "here" (line 3) and finds that the answer (line 4) is one that she can approve (line 5) and with which she can affiliate (line 7).

[11] "Hm un," like the "nyems" that Jefferson (1978) has described, would seem to allow differing interpretations on the part of a hearer.

Excerpt 9 (13/9.208)

1 →	1. Carrie:	Ya like it up here though?
2 →	2. Abby:	Yeah! I really do. It's different, I mean.
P →	3. Carrie:	How did you decide to come here?
PR →	4. Abby:	The area. Just, you know, cause it's Santa Barbara.
3 →	5. Carrie:	Mm that's good.
	6. Abby:	That oughta be it. hunh
→	7. Carrie:	It's why I did t— well, yeah, it's why I came up here too.

These secondary queries appear to follow equivocal or minimal replies to perspective-display invitations. In excerpt 8, Jenny's "hm un" is minimal and its ambiguity or equivocality is evidenced in Lisa's abandoned utterance, which may have been requesting repair ("you di—", line 7). In excerpt 9, Abby at first confirms the proposal in Carrie's query ("Yeah!" line 2), intensifies it ("I really do"), but then equivocates by producing a qualification ("It's different, I mean"). This latter, representing a move from a clearly positive term to a more neutral one, downgrades her initial position.

While the probes could simply be asking for a more extended and/or less ambiguous reply from a recipient, there is clearly more to it than that. The additional material that inviters seek seems related to their own positions, as revealed in the report that is ultimately produced. That is, in excerpt 8, Lisa follows Jenny's reply with a marked query proposing San Diego State as "easier," with the consequence that the subsequent description of her friends who "never study" fits with that proposal as well as with the affirmative reply it receives. In excerpt 9, following Abby's response to Carrie's solicitation of an account for her being at the local college, Carrie strongly expresses approval of the reason offered and pronounces it as her own motive. Thus, if inviters have reports that potentially agree with a position of a coparticipant's, they may first elicit the precise material—some qualification, specification, or explanation of recipient's assessment—such that their subsequent reports can exhibit close accord with what the recipient says.

Coimplicating Recipients' Perspective in the Third-Turn Report

The PDS is a device by which one party can produce a report or opinion after first soliciting a recipient's perspective. The PDS can be expanded through use of the probe, a secondary query that prefigures the asker's subsequent report and occasions a more precise display of recipient's position. Agreement and other exhibits of affiliation between recipient's and asker's displayed positions are preferred features of the device's use. As a result of this organization, the perspective-display invitation and the prompts that may follow it operate in a dual fashion. Because an

asker's report occurs subsequent to a recipient's assessment, and proposedly affiliates with that perspective, the report *seconds* or *confirms* the recipient's position. Additionally, in that the query, probe(s), and report seem to enact an opinion-based conversational trajectory of asker's own, and in that they solicit material that facilitates the trajectory, the series confirms a recipient's perspective *in relation to the inviter's own.* In a sense, the recipient's position is exploited to reinforce or affirm the position in the inviter's report. In proposing affiliation with a coparticipant's perspective, the asker embeds that perspective as a constituent feature of the report and of the asker's own assessment, which that report adumbrates. All of this suggests that the recipient's position becomes *coimplicated* in the asker's report.

So far, excerpts have been from conversations between unacquainted parties. Acquainted parties, through the PDS, show similar interactional sensibilities in their encounters. One example was briefly summarized earlier; the following example is from Pomerantz (1984*b,* pp. 621–22), and occurs when a mother and father are visiting their son and his wife. Because the son has long hair, the parties may regard the long hair of a mutual friend, John, as analogous to the son's hair (Pomerantz 1984*b,* p. 622). A PDS regarding John's hair is arrowed at lines 5–8.

Excerpt 10 (Pomerantz data, simplified)

1.	Mo:	Is the uh piece of sculpture one of your friends made for you?
2.	So:	Yeah. That's John. He cut his hair by the way.
3.	Mo:	Oh he did?
4.	So:	Yeh
1 → 5.	Mo:	Do you like it?
2 → 6.	So:	Uh, yeah, he looks—
3 → 7.	Mo:	I heard— uh, I read two or three columns and I hear it over TV
→ 8.		that it's become old— it's becoming passé.
9.	Fa:	They what?
10.	Mo:	The longer hair.

A conventional way for the mother to receive the report of John's having cut his hair (line 2), Pomerantz (1984*b,* p. 622) argues, would not be only to mark it as news, as she does at line 3, but to then assess or evaluate the news. Instead, she asks the son for *his* opinion (line 5), which appears positive (line 6), and she then produces a report (lines 7–8) that could imply approval of the haircut. If long hair is "becoming passé," that is, it would indicate that John, in cutting his hair, has made an appropriate choice.

The mother, as Pomerantz suggests, is being cautious both by asking the son for his view and by displaying a view that officially belongs to others. "The mother, in all likelihood, is quietly unhappy with the son's

long hair and hopes that he will cut it. She seems reluctant to voice views that would be heard as critical of the son's long hair. This includes making comments about other men with long hair. She transmits a view (read in the newspaper and heard on television) that long hair is passé. That view, if true, could be a reason for the son to cut his hair" (Pomerantz 1984*b*, pp. 622–23). If the mother is indeed feeling that she would like her son to cut his hair, she manages to convey this without being directly critical of him. Note here a rhetorical or persuasive aspect to the PDS. In any case, well-acquainted parties can use the PDS when their circumstances warrant caution. Where one party has a concern or opinion to express, she can do so by first "testing the waters" for the degree of hospitality that the expression might meet. Then, provided that there is a reasonably close fit with what her own report implies, she can deliver that report in an auspicious environment.

If it is possible to simply and parsimoniously offer a report or opinion in conversation, a reasonable question is why the parties sometimes use the more circuitous PDS. One answer is that the straightforward strategy is more workable for acquainted parties who, as "consociates" (Schutz 1962), already know each other's background knowledge and attitudes. Acquainted parties can therefore gear the display of opinion to such understanding of the other. Still, there may be situations among acquainted persons when, for example, being a "mother" can mean a certain touchiness in regard to commenting on a son's appearance, or when one party has a "concern" about a common friend to convey to another, where the cautiousness of the PDS is appropriate. For unacquainted parties, who do not know their coparticipant's knowledge, beliefs, and opinions, straightforwardly offering a report or opinion might engender various troubles. At the very least, one may say something that the other party does not understand. More problematic is that one might affront the other party and put that party in the position of choosing to remain silently offended or having to perform the dispreferred activity of disagreeing with the first party's assertion. By using the PDS, one can work to deliver a report in a preferred fashion, as in agreement with the recipient's own position on some matter.

The PDS in ordinary conversation, then, represents a cautious way of introducing an opinion or assessment because parties can immediately and in situ gauge the degree of fit between their respective stores of knowledge and positions in regard to some social object. Stated differently, the series allows one party to deliver reports and make assessments of social objects in a way that is sensitive to another party's understanding or perspective and to simultaneously provide for a favorable response to the delivered report. Overall, the PDS permits reports and opinions to be delivered in a way that proposes a mutuality of perspective.

THE PERSPECTIVE-DISPLAY SERIES IN CLINICAL DISCOURSE

Although bad news is "woven tightly into the fabric of social life" (McClenahen and Lofland 1976), its conveyance is an arduous experience for the bearer and recipient alike. This is especially true in clinical situations where severe illness and death are recurrent topics (Clark and LaBeff 1982; Glaser and Strauss 1965; Maynard, 1991*a;* Sudnow 1967; Svarstad and Lipton 1977). In clinics, the PDS can be adapted to the delivery of "bad" diagnostic news. Clinicians, rather than presenting a diagnosis straightforwardly, often take the more circuitous route of eliciting the view of their recipients before reporting the clinic's findings.[12] Inbuilt features of the PDS, in particular, its way of setting up a hospitable environment for the telling and its exhibiting the recipient's perspective as an embedded feature of a diagnostic presentation, handle various difficulties of the bad news experience.[13]

Simple Diagnostic News Deliveries

Delivery of a diagnosis, through use of a PDS, is relatively *simple* or *complex* depending upon the nature of the recipients' elicited perspective in relation to the clinical position. For reasons of space, it is easier to demonstrate the structure of simple deliveries, but it should be kept in mind that complex ones extend the same basic pattern. Every step of diagnostic news delivery that uses the PDS involves coimplicating recipients, such that when some ultimate diagnostic term is produced, it appears as something on which deliverer and recipient converge. Stated differently, the PDS and related mechanisms of delivery involve the participation of recipients, including step-by-step demonstrations of their alignment with the clinical position, so that, in the end, the clinician leads the recipient to the diagnosis in a way that implies a mutuality of perspective.

Simple-form diagnostic presentations involve *confirmations,* through

[12] A detailed comparison of straightforward and circuitous deliveries can be found in Maynard (1991*b*). Here I concentrate mostly on the circuitous method in which the clinician elicits a recipient's perspective before giving the diagnostic news. As in ordinary conversation, a feature of using the PDS in discourse is that it is a more cautious and less presumptive means of presenting diagnostic information.

[13] Use of the PDS may be related to another conversational phenomenon. A way of handling the difficulties in giving bad news is to arrange a telling so that the recipient rather than the bearer of the news ends up pronouncing it (Schegloff 1988). In general, the deliverer of bad news need not be someone who has completely independent knowledge to convey; instead the deliverer can be someone who is joined in a telling because of the in situ elicitation and display, as a resource for the telling, of what a recipient already knows or believes.

which a clinician displays agreement and offers to modify or reformulate the recipient's displayed view, and then elaborates on the diagnosis. The next excerpt shows the pattern; it begins with a perspective-display invitation (line 1) and a reply (lines 2–4). The third turn of the series takes up at line 8.

Excerpt 11 (8.013)

1 →	1.	Dr. E:	What do you see? as— as his difficulty.
2 →	2.	Mrs. C:	Mainly his uhm— the fact that he doesn't understand
→	3.		everything and also the fact that his speech is very hard to
→	4.		understand what he's saying, lots of time
	5.	Dr. E:	Right
	6.	Dr. E:	Do you have any ideas WHY it is? are you— do you?
	7.	Mrs. C:	No
3 →	8.	Dr. E:	Okay I you know I think we BASICALLY in some ways agree with
→	9.		with you, insofar as we think that D's MAIN problem, you know
→	10.		DOES involve you know LANGuage,
	11.	Mrs. C:	Mm hmm
	12.	Dr. E:	you know both you know his— being able to underSTAND, and know
	13.		what is said to him, and also certainly also to be able to
	14.		express, you know his uh thoughts
	15.		(1.0)
	16.	Dr. E:	Um, in general his development . . .

In her reply to the opinion query, the mother, Mrs. C, formulates her son's problem (lines 2–4), after which Dr. E produces a token of agreement (line 5). Subsequent to a question-answer sequence concerning why there is a problem (lines 6–7), the clinician, although qualifying himself, more fully expresses agreement with Mrs. C's perspective (lines 8–9). Next, he *reformulates* the parent's complaint about D's understanding and speech as involving a "main problem" the child has with "language" (lines 9–10). The reformulation here involves a slight but technically important shift between the mother's reference to understanding and "speech" and the clinician's use of "language." Clinicians regard language as the more fundamental and encompassing deficit, which can be reflected in speech symptoms. Thus, the reformulation may be offering a "correction" that is instructive for the mother's understanding of clinical terminology (see Jefferson 1987). Dr. E also precedes the reformulation with emphasis on the verb "does," which is a way of tying to the recipient's prior assessment and further marking agreement with it. Following Mrs. C's receipt—a "continuer" (line 11; see Schegloff 1982)—Dr. E *elaborates* the diagnosis (lines 12–14), incorporating one term ("understand") that repeats what Mrs. C has said (line 2) and also using another ("express his thoughts") that is a close version of Mrs. C's reference to "speech" (line 3). Thus, a confirmation, reformulation, and

elaboration of the child's condition all occur and, in several ways, coimplicate the recipient's perspective in the diagnostic news.[14]

Rather than being something done simply and declaratively, confirming deliveries are *achievements*. That is, not just anything a parent says will offer the proper environment for a diagnostic news delivery. For instance, in replying to a perspective-display invitation, parents may take a position that there is no problem. Clinicians with bad diagnostic news to deliver are not, then, in a position of being able to agree. Nevertheless, they can elicit or relevantly introduce problem-oriented talk. One way clinicians do this, as I will show later, is to introduce a reason-for-the-clinic-visit statement. Another way is to listen for or encourage talk in which some diagnosable condition or difficulty is eventually broached.

Excerpt 12 (47.001)

1.	Dr. E:	How's B doing?
2.	Mrs. M:	Well he's doing uh pretty good you know especially in the school.
3.		I explained the teacher what you told me that he might be sent
4.		into a special class maybe, that I wasn't sure. And HE says you
5.		know I asks his opinion, an' he says that he was doing pretty
6.		good in the school, that he was responding you know in uhm
7.		everything that he tells them. Now he thinks that he's not gonna
8.		need to be sent to another
9.	Dr. E:	He doesn't think that he's gonna need to be sent
10.	Mrs. M:	Yeah that he was catching on a little bit uh more you know like
11.		I said I— I— I KNOW that he needs a— you know I was 'splaining to
12.		her that I'm you know that I know for sure that he needs some
13.		special class or something
14.	Dr. E:	Wu' whatta you think his PROblem is
15.	Mrs. M:	Speech
16.	Dr. E:	Yeah. yeah his main problem is a— you know a LANguage problem
17.	Mrs. M:	Yeah language

The query in line 1 initially obtains a positive assessment from Mrs. M (line 2). However, in the course of reporting a conversation with her son's teacher (lines 3–13), Mrs. M exhibits a position implying that she sees B as having a problem ("I know for sure that he needs some special class or something," lines 12–13). Dr. E immediately follows this with a perspective-display invitation that takes up the implication and returns it to Mrs. M for ratification. Indeed, Mrs. M replies with a formulation of the problem ("speech," line 15). Then, through Dr. E's use of two

[14] After Dr. E's initial elaboration, there appears to be no explicit receipt on the part of the mother, unless she provided some nonvocal response (line 15). Nevertheless, Dr. E progresses to a further elaboration of the diagnosis. As documented by Heath (in press), the silence at line 15 may be typical. Summary assessments or diagnoses in regular medical interviews are often met with silence, after which the physician moves to a related topic.

"yeah" tokens and a reformulation ("language problem," line 16), the delivery of diagnosis occurs as a confirmation, although in suggesting that this is a "main problem" (line 16), the clinician's acceptance of the parent's view is qualified (as in the prior example). Lines 15, 16, and 17 appear similar to the exposed correction sequences that Jefferson (1987) identifies,[15] and this excerpt, like 11, therefore may have an instructive aspect to it. Additionally, the parent in excerpt 12 receives the diagnosis by changing her terminology to match the clinician's (line 17). Subsequently (in talk not reproduced here), Dr. E elaborates the diagnosis using words that further incorporate the recipient's displayed perspective. Overall, then, the way in which the recipient's perspective is coimplicated in the delivery of diagnostic news here is similar to the previous example, with the exception that the clinician must strategically deal with an initial positive assessment on the part of the parent. Thus, the simple type of delivery is an achievement in that it depends on recipients' presenting not just anything in reply to a perspective-display invitation, but just that material which allows agreement and confirmation to be produced and to precede a reformulation and elaboration. When such material is absent, a clinician will work to obtain it.

Complex Diagnostic News Deliveries

Complex deliveries involving the PDS become so in at least two ways. One is that clinicians may repeatedly probe parents in regard to their view of the child. This is the case with the interview in the Appendix, where the physician asks Mr. and Mrs. C over a dozen times for their concerns and ideas about their daughter J. The pattern is similar to that in ordinary conversation. Following the initial query and reply, the probes elicit more precise displays of the parental perspective, which the doctor can confirm, reformulate, and elaborate upon in presenting clinical information. A second and related way that news deliveries become complex is when, relative to the parent's lay formulation, the clinician presents an upgraded and exhibitedly more serious diagnosis. Analysis of these more extended episodes shows that even when parental and clinical positions are far apart, using the PDS minimizes the potential for conflict. In one interview, for instance, the parents thought their child's

[15] Such correction sequences have the following format (Jefferson 1987, p. 88): "1. A speaker produces some object (X), 2. A subsequent speaker produces an alternative (Y), 3. Prior speaker produces the alternative (Y)." And therefore it seems that part of the clinician's job is to correct lay perspectives. However, the interjection of agreement tokens before the alternative term in excerpt 12, rather than rejecting an initial formulation as in a correction sequence, initially accepts and thus confirms that formulation.

basic problem was hyperactivity, that it was temporary, and that there was no brain damage.[16] The clinical position was that the child's hyperactivity was simply one symptom among many, that the various problems were *not* temporary, and that they were indicative of a more fundamental condition, which was, in fact, brain damage. Through use of a PDS, however, the disparity between perspectives was reduced, and, rather than occurring argumentatively or conflictually, the informing occurred harmoniously and affirmatively.

Thus, after hearing the mother's view, the clinician confirmed that hyperactivity was a problem and then proposed *converting* it to one among several symptoms that were indicative of brain damage. As in excerpts 11 and 12, this had certain corrective and instructive aspects to it. The parent agreed to the clinician's proposal and assented to the existence of the other symptoms, thereby collaborating in an account for the diagnosis of brain damage. This account then figured in the pediatrician's third-turn delivery of the core diagnosis:

Excerpt 13 (30.186)

1.	Dr. L:	Now when you say: uh you know, the term something wrong with the
2.		brain, is very vague, we don't like it, you don't like it.
3.	Mrs. C:	Yeah right.
4.	Dr. L:	But when we have to describe B's problems, we would have to
5.		say that there is something, that is not
6.	Mrs. C:	Yeah.
7.	Dr. L:	working right in the brain,
8.	Mrs. C:	Mm
9.	Dr. L:	that's causing these things. It's causing the hyperactivity, it's
10.	Mrs. C:	Yeah
11.	Dr. L:	causing him ta see the world, in a different way, from other
12.		children,
13.	Mrs. C:	Mm yeah.
14.	Dr. L:	It's causing him to be his thoughts to be maybe a little
15.		disorganized, when he tries ta order the world,
16.	Mrs. C:	Mm
17.	Dr. L:	in his mind. And if you know, we had ta say, uh if we had ta
18.		give a diagnosis you know when you write away to schools or ta
19.		other doctors, you have to write something down as a diagnosis.
20.		I feel that hyperactivity, just alone, wouldn't be enough.
21.	Mrs. C:	Mm hmm
22.	Dr. L:	and that we would have ta say something like brain damage.
23.	Mrs. C:	Mm hmm
24.	Dr. L:	in terms of B's problems
25.	Mrs. C:	Mmm.
26.	Dr. L:	Because it's a kind of thing that's— it's not just hyperactivity
27.		that's gonna be helped with a little medicine. He is going to
28.		need a special education all the way through.

[16] This interview is extensively analyzed in Maynard (in press). See also n. 7 above.

29. Mrs. C: Uh ha.
30. Dr. L: We feel.
31. Mrs. C: Yeah.

The clinician also *identified* with the parent by displaying her own resistiveness to the diagnostic term (she portrayed herself as not liking it and as being "forced" to use it in lines 1–2, 4–5). After that, Dr. L suggests that "something . . . not working right in the brain" (lines 5, 7) is causing the symptoms that had been agreed upon earlier. Here, these symptoms (hyperactivity, seeing the world in a different way, having disorganized thoughts) are reassembled in a three-part list (lines 9, 11–12, and 14–15, 17), a rhetorical device that, by suggesting a sense of completeness and unity (Atkinson 1984, p. 57; Jefferson 1989) to the package of symptoms, artfully renders an appeal beyond the sheer content of the list. And each part of the list meets with agreement tokens (lines 10, 13) or other continuers (lines 16, 21, 23) that permit Dr. L to progress to delivery of the official diagnosis (lines 22, 24). Thus, as opposed to being some unilateral declaration of Dr. L, the list is collaboratively produced. Accordingly, to the extent that this list serves as a warrant for the upcoming diagnosis, the basis for the warrant is in the parent's as well as the clinic's perspective. In complex ways, the use of a PDS in this interview permitted seemingly disparate views of a child to be reduced.[17]

If parental-clinician disparity is reduced, it is nonetheless managed without compromise. That is, it seems that the PDS and related devices do not involve negotiation over the existence, nature, and duration of problems. Instead, proposing to bring a parent's perspective in line with their own position, clinicians use the series persuasively. It is by way of containing a recipient's perspective as an embedded feature that such deliveries may convince the recipient to align with the clinical position.[18] A further effect of using the PDS is to portray the clinician not as one whose assessment is an independent discovery, nor the recipient as one who must be moved from a state of ignorance to knowledge. Rather, the recipient is one who partially knows the truth, and the clinician is one who, in modifying or adding to what a recipient already knows or believes, proposes to ratify that perspective.

Insofar as the PDS helps solve a generic problem of bad news deliveries, then, there is an interactive aspect to it. Both presenting and receiving bad news are enormously difficult experiences. A solution to the difficulty seems to involve constructing the news delivery so that bearer

[17] Other features of this interview, especially the reference to "schools," "doctors," and "special education" will be discussed below.

[18] In discussing uses of agreement between clinician and parent, Strong (1979, p. 112) suggests that parents "were treated as persons who could be persuaded, once they knew the facts."

and hearer are mutually involved. By eliciting recipients' perspectives, clinicians can proceed to give diagnostic news in a relatively hospitable conversational context and can include recipients' perspectives as constituent elements of the report. Also, where the diagnostic report is possibly controversial, use of the PDS might have rhetorical advantages, as it does in ordinary conversation.

In these ways, therefore, the PDS is a conversational mechanism that is *adapted* to the clinical setting. In ordinary talk, persons use the series to deliver a report, assessment, or opinion in a confirmatory way. In conversations among both unacquainted and acquainted interactants, the production of potentially controversial displays of perspective in a serial way shows a mutuality of perspective. Similarly, professionals can employ the series when informing parents or patients of highly charged diagnoses. This at least works to promote parents' *understanding* of what may be technically difficult clinical jargon and terminology. Additionally, by coimplicating their recipients' knowledge or beliefs in the news they have to deliver, clinicians also present assessments in a publicly affirmative and nonconflicting manner, show sensitivity to their relationships with parents or patients, and work to convince them of the clinical position.

DIFFERENCES BETWEEN CLINICAL DISCOURSE AND ORDINARY CONVERSATION

If talk in institutional settings is, in basic ways, continuous with that in ordinary life, it is also dramatically different. Inspecting detailed aspects of the PDS in clinical settings reveals significant disparities, and these lend to or are part of the asymmetry in the doctor-patient relationship. First, as in ordinary conversation, there are both "marked" and "unmarked" perspective-display invitations. In the clinic, however, both kinds of queries seek a single end, which is producing the situated sense of children "having problems" that are in need of remedial, expert attention. Thus, participants in the discourse constitute children as clinical objects (cf. Silverman 1981) and simultaneously provide for the clinician to pronounce an authoritative version of the child. In part, this authority derives from the reflexivity of "problem proposals" to the seeking of professional expertise. Second, even though the PDS partakes of an independent order of interaction, clinicians and parents produce opinions and reports through contrastive displays of knowledge that enact deference and authority. They thereby show an *orientation* to the institutional environment. A final distinguishing feature of the PDS in clinical settings is a rigidity of use that contrasts with the flexibility of ordinary conversation. Such rigidity removes some of the contingency that is inherent in

conversation and can make clinical discourse appear more predictable and manipulated than the former.

Problems and Problem Proposals: Marked and Unmarked Queries

In clinical discourse, as in conversation, perspective-display invitations are either *marked* or *unmarked*. If they are marked, it is regularly in the "negative" direction; that is, a query will initiate reference to a problem as a possession of the queried-about child.

Excerpt 14 (8.013)
Dr. E: What do you see? as— as his difficulty.
Mrs. C: Mainly his uhm the fact that he doesn't understand everything. And and also the fact that his speech, is very hard to understand what he's saying.

Excerpt 15 (14.012)
Dr. E: What do you think is his problem? I think you know him better than all of us really. So that ya know this really has to be a, in some ways a team effort to understand what's going on.
Mrs. D: Well I know he has a— a learning problem, in general. And speech problem an' a language problem. A behavior problem, I know he has all o' that but still, in the back of my— my— my mind I feel that he's t— ta some degree retarded.

Invitations that contain references to a difficulty or problem are suggestions or proposals that parents usually accept.

Unmarked invitations do not refer to a problem. The first example here is from our focal interview (see the Appendix).

Excerpt 16 (9.001)
Dr. S: Now that you've— we've been through all this I just wanted know from YOU. HOW you see J at this time.
Mrs. C: The same.
Dr. S: Which is?
Mrs. C: Uhm she can't talk . . .

Excerpt 17 (47.001)
Dr. E: How's B doing?
Mrs. M: Well he's doing uh pretty good you know especially in the school.

Although by different means, both marked and unmarked invitations seek an alignment between parent and clinician on the issue of the child having a problem.

Marked queries.—This sought-after alignment is clearer with marked queries (excerpts 14 and 15), wherein parents produce complaints in which they specify some problem of the child. In the bulk of cases, the marked perspective-display invitation and its reply both reference difficulties of a child in these routine and certain ways. That is, parents

converge with clinicians on the position that the child has a problem, and the issue becomes one of what it is and what can be done about it. After the parents display their views, clinicians can easily deliver official findings and diagnoses. Nonetheless, initiating the delivery of diagnostic news with a closed query is a *presumptive* move, which becomes visible when parents disagree with a clinician's query (see Maynard 1985, p. 15). Instead of responding with a problem formulation, parents may take issue with the notion that there is a complainable aspect of the child. Thus, in one interview where both parents were present, the clinician made an inference from the family's application that they understood "a fair amount about what C's problem is." The mother affirmed that inference, but when the doctor, euphemistically referring to the child's problem as "the situation," invites the father to display his view, the father disagrees with the proposal:

Excerpt 18 (22.007)
Dr. N: And we haven't really had a chance to hear from YOU at all as to what you feel the situation—
Mr. G: Well I don't think there's anything wrong with him.

To assert such disagreement necessitates breaking the "frame" of the invitation; rather than producing a canonical reply—a problem formulation or complaint about the child—the parent addresses the proposal that the child has any difficulty at all.

The contrast with ordinary conversation is stark. There, marked invitations are mostly in the positive direction. Those that expect negative assessments or complaints occur in relation to prior talk or knowledge that some item is a "complainable." For example, an announcement of trouble may immediately precede and inform a negatively marked invitation (see excerpt 5 and discussion). In the clinic, of course, the analog to an immediately prior announcement of trouble is a whole series of previous encounters and ceremonies in which others have formulated problems and difficulties of a particular child. Thus, to argue that marked perspective-display invitations suggest or propose a problem as the possession of some individual child is not to say that clinicians have unilaterally discovered a problem and coercively seek to label the youngster. When clinicians produce a marked query, instead of themselves making an initial proposal, they may be furthering someone else's claim or presumption, one that derives from the parents, the school, or some other source (Booth 1978; Davis 1982, p. 137). When recipients of the invitation display their view by producing a description of the problem, they are agreeing with the position that the child has a problem and that constitutes acceptance of the problem proposal and advances the presumption or claim.

Unmarked queries.—Perspective-display invitations that ask in more generalized terms about the child are not presumptive in this way. This means they could be asking whether any problem even exists and, if so, wherein it lies. It might appear that clinicians are investigating parents' views as part of the diagnostic process, attempting to discover whether any pathology exists for the child under consideration. Or they might be inviting a "troubles telling," with parents as speakers and themselves as recipients (Jefferson and Lee 1981). In fact, unmarked queries, at least in these data, do not work in these ways, but rather, like their marked cousins, seek and require problem formulations and complaints about the child, which the clinician can address.

That unmarked invitations solicit problem formulations can be established in several ways. First, unmarked queries often cue the parents that they are asking about the family's *clinical* experience rather than any other. Although asking in a generalized manner for the parents' view of the child, unmarked invitations regularly have temporal formulations, which include terms such as "now" and "at this time," and may contain locational formulations, such as "here" and "through this," which refer to the clinic as a "course of action place," or location that is identifiable by its internal activities (Schegloff 1972, p. 101). When these formulations appear in the invitation, they are mirrored explicitly or implicitly in the reply. Refer again to our focal interview or excerpt 16 above, wherein the clinician asks Mrs. C, "Now that you've—we've been through all this I just wanted to know from you how you see J at this time?" Mrs. C's reply, "the same," is an "indexical" expression (Garfinkel 1967) and comparative term that ties to the clinician's utterance and thereby invokes "as before" and "at entry" for understanding. In other words, "the same" can be heard as proposing "at this time" a condition of the child that has a relationship of identity with one that existed when the family first entered the clinic. Because of these temporal and locational formulations, it should be no surprise that, in answering unmarked invitations, parental recipients regularly produce complaints about children's problems. Again referring to the focal interview, recall that the parents immediately go on to produce descriptions of J's difficulties in talking.

Furthermore, when temporal and locational formulations or other cues are not present in an unmarked query, the parent may reformulate it as asking for a problem proposal (parentheses indicate ambiguity with regard to who is speaking or what is said):

Excerpt 19 (16.006)

Dr. V: What is your impression of what's going on with A?
(Mrs. G): (Uh::m) (mm)
→ Mr. G: You mean what seems to be his problem?
Dr. V: Yeah, what— what— how do you see your son.
Mr. G: Uhm well the main thing is not listening.

In a variety of ways, then, it is provided for parents to "hear" unmarked perspective-display invitations as asking for a problem formulation.

Still, unmarked queries may fail to occasion an immediate complaint and problem proposal from parents (see excerpt 12), in which case the clinician will employ various strategies to obtain them. One is to remind parents of why they came to the clinic. This occurs in one case where a pediatrician asked, "How has M been?" The parent, Mrs. S, replied that she did not "think anything is wrong with [him]." Dr. V then suggested there was a previous screening that turned up a speech or language problem, to which Mrs. S responded, "Right." Another strategy involves the clinician listening for or encouraging talk from the parent to which a problem proposal can eventually and relevantly be attached. This can be seen in an ordered relationship that exists between unmarked and marked invitations when they both appear in a single interview. Marked invitations may occur subsequent to unmarked ones (but not the reverse), as excerpt 12 above shows. Initially, Dr. E. asks Mrs. M, "How's B doing?" (line 1). Mrs. M replies that her son is doing "pretty good" in school but goes on to report a discussion in which she had "explained" to B's teacher that "he needs some special class or something." Immediately after this, Dr. E produces a marked query, "Well what do you think his problem is?" (line 14). This query, then, is not issued after the unmarked one (and its reply) in some kind of mechanical fashion. Rather, it takes up an implication from Mrs. M that her son has a problem and thus can be furthering her claim rather than initiating a new one.

Use of a marked perspective-display invitation, in summary, presumes that the child does indeed have a problem. That presumption works to continue an interactive claim. It is most often honored, but it can be dishonored, and this results in initiatives to achieve the presumption as a mutual one before progressing through the series and delivering a diagnosis. Unmarked queries may occasion other kinds of preliminary talk but also ultimately work to elicit problem formulations. Both marked and unmarked queries, therefore, interactionally help establish a taken-for-granted notion that some child "has a problem" and is a proper clinical object, a notion that reinforces the visibility of the clinician's own expertise. This is because of the reflexive relation between problem proposals and the help-seeking trajectory by which a family arrives at the clinic. The evidence for this reflexivity is in the way clinicians handle parental resistance to producing problem proposals. As we have seen, a clinician may then recall the reason why the parents came to the clinic and elicit agreement that there was a problem for which help was originally sought. Aligning on the claim that a child has a problem is thereby linked with a presumption that seeking expert help is part of the legiti-

mate history by which the family and child arrived at the clinic. Insofar as participants organize their search for help according to a social distribution of knowledge in which professionals are proper to consult (Sacks 1972), that is, the authority of clinicians and the relevance of their speaking are evoked at the very moment when the parties establish that the child has a problem. The asymmetry of clinical discourse, then, eventuates in part from a managed convergence between clinician and parent on the existence of a child's problem.

Contrastive Displays of Knowledge and the Orientation to Social Structure

If participants collaboratively provide for the clinician's display of authority, the PDS performs a constitutive function in clinical discourse. The social fact of clinicians having the authority to diagnose and treat patients' problems, rather than being imposed from without, is constituted in the immediacy of interaction. But it is not just that the actors *provide for* a display of authority by aligning on the proposal that a child has a problem. Clinicians and parents have different ways of assessing such problems; they engage in contrastive displays of knowledge (cf. Tannen and Wallat 1987) and immediately enact the complementariness of authority and deference of their situated identities. In Wilson's (1991) terms, they demonstrate a sensitivity to the nature of the setting and an *orientation to social structure*.

In ordinary conversation, assessments, as products of participation in social events or of other experiences with social objects, are claims to knowledge of those events or objects (Pomerantz 1984*a*). Thus, through use of the PDS, parties produce opinions and reports on the basis of direct acquaintance with the social object in question or on the basis of what they have "heard" regarding it. In the clinic, while parents still operate that way, claiming personal experience within narratives regarding their child, they do so hesitatingly. Parents' replies to solicitations of their view are often marked with disclaimers ("I don't know"), qualifiers ("maybe"), and other devices that downgrade the status of their exhibited view. Such qualifying tokens and phrases may be encouraged in the precise construction of perspective-display invitations:

Excerpt 20 (33.001)

1. Dr. B: Well you've been through a lot of tests with him, seen a lot of
2. different doctors. Do you have any idea of what you think is the
3. problem?
4. Mrs. M: I don't know, I— I don't know even myself. Once me and my
5. sister ( ), she said maybe my ( ) was
6. too close. Or maybe they was too close. My one sister told me

7. maybe I didn't need, you know, maybe if I just had him by himself,
8. he'll act, you know better.

In querying the mother for her "idea" and what she "thinks" the problem is, the utterance elicits a reply that is a *subjective* one, an opinion, following which the clinic's report (as we shall see) can be contrastively displayed as *objective,* as a finding (Anspach 1988, p. 368). Related to this is that, in asking, "Do you have any idea of what you think is the problem?" the physician employs a reference term, "you," which is contrastable to the "we" of the clinic and captures the lay/professional partitioning of the "membership categorization device" by which people organize the search for help (Sacks 1972; see also Strong 1979, p. 82). Finally, the reference to "problem," insofar as it is a selection from alternatives such as "trouble," proposes "advice giving" as opposed to "troubles telling" or some other activity as the focal event of the encounter (cf. Jefferson and Lee 1981, p. 411; ten Have 1989).

Clinicians, in contrast to parents, assertively base their reports on purportedly sounder evidence, their tests. When the physician from our last excerpt moves to deliver the diagnosis, it follows further talk in which, in reply to a prompt from Dr. B regarding the nature of M's problems, Mrs. M says, "I don't see why he don't talk."

Excerpt 21 (33.059)
Dr. B: We feel that the problem is that he CAN'T yet. And that he—
our— ALL our exams show that he is quite retarded.

The clinical assessment is initially stated in subjective terms, Dr. B using a "state-marker" preface ("we feel that . . .") and thus depicting the position ("the problem is that he CAN'T [talk]") as contingent upon processes internal to the viewer(s).[19] However, when moving to deliver the diagnosis, Dr. V prefaces it with a phrase ("ALL our exams show," line 8)[20] proposing that the diagnosis is a conclusion from external evidence. A regular feature of clinicians' diagnostic news delivery is its *grounding* in what they have "found" by virtue of testing, evaluation, and other "objective" measures (Maynard 1989*b;* Mehan, Hertweck, and Meihls 1986).

[19] The state marker here appears to do other work as well. By delaying production of the position report, which is a partial disagreement with Mrs. M's implication that her son's not talking is a willful matter, it mitigates the report's assertiveness, and therefore perhaps is a strategy that is affiliative rather than confrontive (see Pomerantz 1984*a*).

[20] Compare this to Anspach's (1988, pp. 367–68) discussion of how clinicians may use medical technology as an agent ("The EEG showed . . ."), and thereby omit reference to how tests and procedures require interpretation.

Beyond being a different way of adducing evidence for a third-turn report, the reference to test results, as a claim of expert knowledge in the delivery of diagnostic news, is an element in the lcoal social organization of talk that has a structural basis in another setting (the examination), whose interactive logic is itself worthy of investigation (Cicourel 1981, p. 73; Marlaire and Maynard 1990). Access to and knowledge of other settings, moreover, may be a resource for the assertion of authority in a local situation (Cicourel 1987). Consider again excerpt 13, wherein a clinician counters a mother's perception of hyperactivity in her child with a diagnosis of brain damage. When portraying herself as forced to give this diagnosis, she invokes the institutional context—having to "write away" to schools and doctors and the need for special education as opposed to medication—as an explanation for such force. Thus, the very careful movement away from the parent's perspective and toward the clinic's position reflects not just an abstract concern with correct terminology but also a responsiveness to the "context of accountability" (Rawls 1987) in which professionals are embedded. In addition to reporting outcomes of their investigation to families, clinicians must also provide their results to schools, school systems, government agencies, and so on (Mehan et al. 1986; Mehan 1991). The orientation to social structure is clear and concrete.

Rigidity of Sequential Relationships

That the clinical use of the PDS always seems to aim for certifying a child's problem and for providing an official, test-based diagnosis suggests less flexibility for the series than in ordinary conversation. For one thing, we have already noted that the first two turns may be like a presequence. In conversation, if askers discover a coparticipant's opinion to be at odds with their own, hypothetically they can refrain from producing their own report or contrary assessment. In the clinic, however, a physician, even in the face of disagreement with the parent's perspective, will still deliver the clinical diagnosis. For instance, in the case from which excerpt 18 is drawn, where the father did not think "there's anything wrong" with his son, Dr. N followed with a probe:

Excerpt 22 (22.049)
Dr. N: Mister Smith are there any things about C that worry you?
Mr. G: Not a thing.
Dr. N: Nothing?
Mr. G: Nothing.

Further such solicitations were similarly unsuccessful in obtaining any negative assessment from the father. Finally, Dr. N noted the existence of disagreement and forged ahead with the clinic's diagnosis:

Excerpt 23 (22.125)

1.	Dr. N:	Well there's a disagreement on exACtly whether there is a problem
2.		or not. I think rather than belabor the point of whether we—
3.		whether there is a problem or not? I think we should give you
4.		what we found, which is
5.	Mrs. G:	Mm hmm
6.	Dr. N:	after all what you came here for.
7.	Mrs. G:	Mm hmm
8.		(1.9)
9.	Dr. N:	From straightforward pediatric point of view,
10.	Mrs. G:	Yeah
11.	Dr. N:	His general health, after he got over that hundred and three
12.		point eight
13.	Mrs. G:	Yeah
14.	Dr. N:	temperature is— has not been the problem.
15.	Mrs. G:	Yes
16.	Dr. N:	Uhhh but a general evaluation. It was very noticeable some of what
17.		you described.
18.	Mrs. G:	Mm hmm
19.	Dr. N:	C has a problem with language.
20.	Mrs. G:	Mm hmm

Several points are worthy of note here. First, Dr. N precedes and justifies her presentation of findings by submitting that those are what they "came here for" (lines 4–6). As previously noted, in the face of parental resistance to problem proposals, a device clinicians use is to invoke a reason for the family's visiting the clinic. Second, the doctor delivers the clinical assessment in a two-part format that has a good news–bad news structure (Maynard 1989*b*). What is *not* the problem (lines 11–12, 14) occurs first, followed by a description of what problem C "has" (line 19). Sandwiched between the good news and the bad news is an utterance (lines 16–17) that prospectively characterizes the negative assessment as in agreement with what an intake form or application apparently indicated (Maynard 1991*b*).[21] The clinician purports to package the diagnosis as confirming an earlier statement. Insofar as the delivery itself (line 19) occasions some form of receipt and, more specifically, solicits a display of agreement, the clinician thereby encourages yet again an alignment on C's having a problem. The mother seems to provide displays of agreement (lines 13, 15) as well as continuers (lines 18, 20), but the father remains silent during the delivery. If this means holding to his earlier-stated position, then the problem proposal and diagnosis at line 19 exhibit disagreement with that position and, in fact, occur despite that disagreement. In other words, the clinician elected to pursue the third turn of a PDS even after

[21] See the discussion of excerpt 18. Also, Teas (1989) has analyzed the manner in which clinicians may use written parental assessments to smooth the delivery of a diagnosis.

obtaining an opinion from one parent with which the diagnostic information strongly contrasts.

This pursuit of a report is one aspect of the rigidity to sequential relationships in the clinical PDS. Another aspect concerns the relevance of the PDS to subsequent talk. In conversation, agreement on a social object being assessed inspires further topical talk, while disagreement occasions a topic change. In the conversation from which excerpt 1 was taken, Bob and Al, after trading agreeable negative assessments in regard to wire wheels, discussed them rather extendedly (Maynard 1989*a*, pp. 108–9). When John and Judy both registered their negative opinions about bicycles in excerpt 6, they subsequently told stories about how the bicycles affected their riding or walking across campus (Maynard 1989*a*, p. 107). By contrast, when Jane and Alice discover that they have different opinions about George Herbert Mead, in excerpt 7, a topic change occurs (they engage in introductions). Regularly, in conversational data, when an asker's report disagrees with or disaffiliates from a recipient's assessment or position, it results in topic change. Thus, in comparison with agreement, disagreement within a conversational PDS has different "sequential implicativeness" (Schegloff and Sacks 1973) or systematic consequences for the ensuing talk.

In the clinic, this appears not to be the case. Whether agreement or disagreement is the achieved outcome of using the PDS, clinicians will pursue an elaboration of the clinical position by explaining a diagnosis. At best, this can prolong dispreferred activity and wreak discomfort for clinician and client. At worst, it can result in withdrawal by one or both parties. Short of breaking the relationship, that is, clinical discourse seems to provide no escape from the conflict entailed by parties' strong adherence to divergent positions.[22]

Relative to ordinary conversation, Heritage (1984, pp. 239–40) argues that sequential organization in institutional discourse can involve concentration and specialization of sequential mechanisms.[23] The PDS clearly has a concentrated distribution in the clinic that it does not in ordinary talk, due to the kind of solution to interactional problems it represents.

[22] This does not mean that parties to the clinical relationship do not exert efforts to resolve disagreement. Rather, one of the devices for such resolution—exit from the topic—is not used. But topic "shading," recourse to "comforting" a disturbed recipient, modifying extreme differences in perspective, and other devices can all come into play.

[23] See Whalen and Zimmerman's (1987) analysis of how the "sequential machinery" that characterizes openings in ordinary telephone conversations is specialized and reduced in emergency calls (to the police, for example). Thus, recognitional sequences, greetings, and "how are you's" are absent in these calls. Through eliminating them and moving to "first topic," partipants bring about the very institutional context in which they find themselves.

It is, we have seen, a cautious means of delivering bad news, of which clinics often have a surfeit. The PDS is also specialized in that way that it encompasses problem proposals and contrastive displays of knowledge and thereby helps to constitute children as clinical objects and clinicians as authorities to treat them. Beyond this, insofar as disagreement between parental and clinical positions does not provide for exit either from completing the series or continuing to talk on the disagreed-about topic, sequential relationships have become rigid. In the clinical context, in other words, some of the contingency surrounding the way in which sequences are built and the effects they have on subsequent talk seems to be diminished. This rigidity suggests that clinical discourse can be more predictable than ordinary conversation. At times, because what the parents may think appears not to matter for the presentation of a discrepant clinical position, and due to the rhetorical aspects of the PDS, it's use appears more manipulative than in everyday talk. In other words, clinicians may presumptively rely on their abstract authority while giving the *appearance* of incorporating the parent's perspective during a diagnostic informing. Excerpt 23 shows the possible duality or even duplicity here; while the clinician coimplicates one parent's perspective in the delivery, her assertion of the clinical view simultaneously contradicts the very position she had in fact elicited from the other parent.

CONCLUSION

Medical sociologists have suggested that the suppression of patient experience in favor of a clinical perspective permeates doctor-patient interaction. This phenomenon seems apparent in our focal interview (see the Appendix), where the clinician actually asks the parents of a developmentally disabled child for their view, probes them, and then delivers clinical information that relates only to limited aspects of what they say. Analysts account for this phenomenon in various ways that explicate the authority of the physician in relation to the deference of the patient. Doctors have cultural authority that allows them to ascertain what is wrong with a patient and to determine what needs to be done. In some macrosocial views, this reproduces class relations in contemporary capitalism, while in other theories, authority is more pervasive than belonging to just the physician. Medical discourse and its technologies of surveillance control both physicians and patients, and are reaching into every realm of human behavior. Microanalytic analyses, making a case for direct study of interaction, are still somewhat similar to their macro counterparts in arguing that the "voice" of medicine takes precedence over the "voice" of the life world and does so because of a technocratic consciousness among physicians that prohibits mutual dialogue with their patients.

Thus, at the very least, a picture emerges in which clinical discourse represents a radical disjunction from the presumed symmetry of talk in everyday life or, even more extremely, is coming to overwhelm and supplant ordinary conversation. However, research has not actually compared clinical discourse to everyday conversation. Moreover, studies characterize discourse as either being a product of external, institutional forms of organization, or as primarily occupied, to paraphrase Giddens (1984, p. 136), with "mobilizing" the institutional context and its authoritative modes of control. My analyses show that the discourse has an internal logic and orderliness that derive from the interaction order sui generis (Rawls 1987) and in particular its sequential organization (Schegloff 1987). If conversation is "the basic form of speech exchange system" (Sacks, Schegloff, and Jefferson 1974) and is the "home" environment of procedures that can be employed in diverse settings, then a knowledge of ordinary talk is required in order to fully understand the asymmetries in institutional and other discourses (Heritage 1984, p. 240).

From this standpoint, the PDS, as a mechanism for providing diagnostic news in clinical contexts, is the counterpart of a conversational device whereby any person, before delivering a report or assessment, can ask recipients to display their own positions and can then tie the report to what their recipients have said. Whether it manages a problem of understanding or of the fit between the parties' perspectives, the series seems particularly appropriate in social relational circumstances that warrant caution. Little wonder, then, that this device would be adaptable to a clinical environment where pediatricians or other professionals must inform parents or patients of technical and highly charged diagnoses. By adducing a display of their recipients' knowledge or beliefs, clinicians can potentially deliver the news in a hospitable conversational environment, confirm the parents' understanding, coimplicate their perspective in the news delivery, and thereby present assessments in a publicly affirmative and nonconflicting manner. In short, the PDS allows deliveries of news and assessments to be accomplished in a manner of mutuality and social solidarity.

When clinicians do not use the PDS and thus more straightforwardly deliver a diagnosis, they may presume that clinical findings converge with the parents' understanding and views. Such presumptions can be correct, but they can also be incorrect, in which case recipients show extreme forms of interactional alienation and bewilderment.[24] In the de-

[24] See the "Roberts" case and discussion in Maynard (1989*b*). Also the stories in Jacobs (1969) and Darling (1983*a*, 1983*b*) wherein parents recount their experiences of being told the diagnosis of retardation for their children. At times they were as angry and shocked at the manner in which it was presented as at the diagnosis itself.

velopmental disabilities clinic, clinicians then may elicit a display of the parents' perspective *after* presentation of the diagnosis, and thereby work retrospectively to align them with the clinical position (Teas 1989). In routine medical encounters, Heath (in press) similarly shows that physicians who straightforwardly give diagnostic assessments may subsequently elicit responses that indicate the patient's cooperation with the professional perspective. In one instance, after telling a patient that his physical symptoms are due to "anxiety," and the patient produces a minimal response ("mmh"), the doctor asked him, "How would you feel about that?" The patient answered by agreeing with the assessment. Thus, the concern with mutuality sometimes becomes evident in diagnostic presentations that do not involve the PDS, particularly when patients or parents show resistance to the clinical view.

Therefore, the PDS makes transparent interactional concerns that may be at the core of institutional exhibits of authority. Understanding this interactional core, moreover, allows technical explication of such authority. First, through making or eliciting problem proposals in the beginning turns of the series, clinicians provide for the relevance of displaying an authoritative version of a child. Second, through systematically using contrastive forms of knowledge and through making references to the institutional context of a diagnostic decision, participants show an orientation to social structural relationships that reinforce the clinic's authority. Third, sequential relations between turns of the PDS and between the PDS and subsequent talk appear to be more rigid than in ordinary talk, a rigidity that results in more predictability and manipulation in the clinical setting. In sum, while clinical discourse may be asymmetric, it is not so in any unadulterated, comprehensive, or totalistic fashion, but in particular and specifiable ways.

Let us return, then, to the fundamental phenomenon, the suppression of patient or client experience in favor of the clinical perspective. Previous research, including language-based studies, says or implies that this asymmetry represents the imposition of physician's power and authority, which reproduces the society's overall, external, institutional structure. The argument here is that, within institutional discourse, more is going on. Despite social theory—for instance, about the institutionalization of doctor and patient roles (Parsons 1951, p. 424)—it would be an unusual situation if relying on the institutional order were the only means to ensure the stability of the doctor-patient relationship, for it would mean that medical and other professional settings would comprise their own forms of talk and share nothing with mundane encounters (Clayman 1989). To be sure, patients and parents seek expertise in regard to their life world difficulties and receive avowedly official reports and technical versions of these difficulties in ways that promote or reproduce the insti-

tution of medicine. However, if such reports and versions are bad news, their delivery will be predictably difficult in a purely local, embodied, interactional sense. Therefore, clinicians as ordinary members of society can be expected to have devices for handling these interactional difficulties. Exploring such a possibility requires comparative analyses of institutional discourse and everyday conversation, which shows that coimplicating a recipient's perspective in a bad news delivery allows for at least the appearance of understanding and mutuality in this highly charged situation. In short, the asymmetry of discourse in medical settings may have an institutional mooring, but it also has an interactional bedrock, and the latter needs sociological appreciation as much as the former. Finally, if medical discourse has such a bedrock, no doubt various institutional discourses—in legal, educational, and other settings—do as well. Research on such discourse can take seriously the ethnomethodological proposal that, *regardless of the setting,* there is an indigenous orderliness to everyday scenes of social interaction.

APPENDIX

This is a transcription of the beginning part of an informing interview. The details and symbols on the transcript represent conventions that were developed by Gail Jefferson (see, e.g., "Transcript Notation," pp. ix–xvi in J. Maxwell Atkinson and John Heritage, eds., *Structures of Social Action: Studies in Conversation Analysis* [Cambridge University Press, 1984]). They are designed to provide vocal information and prosodic detail (silence, intonation, sound elongation, emphasis, etc.) for a reader's visual inspection, and thus to preserve a sense of the original interaction as it actually and naturally occurred. These conventions are listed below, and the transcript follows the listing.

Transcript Conventions

1. Overlapping speech A: I didn't know [that] B: [It's] true	Brackets denote beginning and ending of overlapping speech.
2. "Latched" utterances A: Let's wait on it. = B: =Okay	Equal signs indicate no interval or gap between the end of one utterance and the beginning of a next.
3. Intervals between and within utterances A: He drove (0.2) uphill. (1.3) B: Yeah? (.) How far.	Numbers in parentheses mark elapsed time in tenths of a second; a period enclosed in parentheses indicates a short gap of one-tenth of a second or less.

4. Speech prolongation A: I did oka::y. B: Goo::::d.	Colon(s) show that a prior sound is prolonged. The more colons, the longer is the prolongation.
5. Intonation A: It's got (0.2) four stories? Yeah. B: It does,	Punctuation marks are not used as grammatical symbols, but for intonation. A period marks downward, a question mark upward, and a comma "continuing" intonation (i.e., slightly rising).
6. Emphasis A: She hadda LOTta books.	Capitalization displays various forms of emphasis or stress, including volume and/or pitch, and so on.
7. Aspiration A: .hhh hhhh I gue(h)ss so	An "h" marks audible breathing. The more "h's," the longer the breath. A period preceding indicates "inbreath"; no period denotes "outbreath." Breath markers may occur between speech particles or in the midst of speech. In the midst of speech, they may indicate plosiveness, as with laughter particles.
8. Transcription conveniences A: Well ((cough)) I don't know. ((microphone noise)) B: ((whispered)) Neither do I.	Materials in double parentheses indicate difficult-to-transcribe vocal sounds, features of the setting, or characteristics of the talk.
9. Inaudible utterances A: (Is that right?) B: ( )	Materials in single parentheses indicate transcribers are not sure about words contained therein. If no words are within the parentheses, this indicates that talk was indecipherable to the transcriptionist.

Transcript of Informing Interview

1. (Start of tape)
2. Dr: . . . Now that you've— we've been through all this I'd just like to
3. know from YOU how you see J at this time
4. (2.2)
5. Mo: The same
6. (0.7)
7. Dr: Which is?
8. (0.5)

Mo: Um she can't talk, I mean she ta::lks but she doesn't you know (0.1) the sound
(0.4)
Fa: It's [not it's not] clear you know
Mo: [Like the: words]
Fa: [she can't speak] word clearly (0.2) [she] can't pronounce uh word or
Dr: [( )] [mmm]
Fa: you know
(0.5)
Dr: mm h
Fa: She just talk like uh a regular other like— the other kids, like babies you know?
Dr: Mm hmm
Fa: Cuz we have smaller kids (0.4) and I— I don't de— de way I see it I think she try to imitate them you know to talk the same way they talk
(0.2)
Dr: Mm hmm
Fa: So in a way maybe she attract more attention because all the times (0.5) .hh you know when uhh one of the smaller kid you know (0.2) s— say something or sounds funny or you know does something funny you know (0.8) we l:augh and uhh:: she looks (at wa) she looks at us and uhh (she know how she gets—) she's jealous
Dr: Mm hmm
Fa: So she tries to act the SAME way so uh you know.
(1.0)
Dr: ( ) .hh do: uh how old are your younger children?
(0.6)
Fa: Mm I think, one and a half or two?
Mo: Uh (0.2) one, a:nd (0.2) the the other one is three
(0.8)
Dr: (Mm hmm) Now the three year old does that—
Mo: He talks
Dr: He talks much [better than J]
Fa: [Yea he does] does uh
Mo: [( )]
Fa: clearer than J
(0.2)
Dr: A:nd (0.2) uh when J was very little and the other two children weren't there she still wasn't
(0.3)
Mo: No
Dr: progressing the way she should=
Mo: =and she usted to do— things that weren't normal, at all
(0.6)
Dr: Like w[hat]
Mo: [You know] hh she use to lick the floor when we used to tell

55. her not to do [that] (0.2) .hh and you know it— like we use ta
56. Dr: [Mm hmm]
57. Mo: When we (useta) teach (all) my sister because my mother had [her]
58. Dr: [Mm hmm]
59. Mo: most of the ti.me hh she use to say like she— you know she couldn:
60. (0.7) sh— it use ta take lo:nger with her to learn things
61. (0.6)
62. Fa: I [don't know (why:) (0.9) I:::— I don't know] I— we were told that
63. Dr: [Why— why do think that this [(you know)]]
64. Mo: [(I don't know)]
65. Fa: she was spoiled
66. (0.7)
67. Mo: No [: but you KNOW I—] this [nurse that saw her I took her to] this
68. Fa: [by her grandmother] [( ) that way some times]
69. Mo: friend of mine's house with my sista, .hh and she's a nur:se and she
70. told me, that girl she don't look like, you know she's nor:mal, and
71. everybody used to tell me the same thing like she was retar:rded or
72. some:thing?
73. Dr: Mm. Is this something that you were worried about? that she might be
74. retarded? (0.1) and that might be the reason
75. (0.6)
76. Fa: (Well) [I can't worry abou—] I can't worry about it because
77. Dr: [for [the language (problem)]]
78. Mo: [( )]
79. Fa: I have to live with [that] I can't worry ((laugh)) .hh
80. [((slap))]
81. Dr: Well: even if you have to live with this, this something you— that's
82. been in the back of your mind? that (0.2) maybe that was the reason
83. why she isn't (0.5) talking?
84. (0.4)
85. Mo: I don't think (0.3) so, I think she just slo:w in learning
86. (0.4)
87. Fa: [That's right] I think sometimes[( )]
88. Dr: [Mm hmm] [Is she] slow in learning everything
89. or there's somethings that she can learn very quickly, some things
90. that [she can pick up on]
91. Mo: [Yes (0.2) some things] she could pick up quicker [than others]
92. Dr: [like what?]
93. (1.0)
94. Mo: Like uhm (1.3) ts— let me see (0.5) LIKE she watches sesame street
95. an th— she know like, uh some of the ABC's she knows an— .hh [and]
96. Dr: [Now—]
97. Mo: to count, like I was saying too, .hh she doesn' know how to count=
98. Fa: =what if she [might be absent minded]
99. Mo: [and the two year o:ld?] he's sm— you know
100. (0.2)

Dr: Mm hmm=
Mo: =He s— I see that he's smarter than her
(0.4)
Mo: [(Well) I mean for] a three year old?
Dr: (ha) [(well what about)] (yeah) what about doing
things like it— (0.4) helping you around the house, setting the
table: or (0.4) dust [ing?]
Mo: [No]
(1.2)
Dr: She doesn't do that—
Mo: No
Dr: How about playing with things like blocks: (0.6) or crayons
Mo: She (knows ho—) I mean, she doesn't play with that she breaks them
Fa: [When she] plays with crayons (.) on the wall
Mo: [Let's put it that way]
(0.4)
Fa: [.hh ha ha .hh ha]
Dr: [.hh she doesn't (.) do it on paper?]
Fa: [No just scribbles ( ) you know they get] carried away
Mo: [No I tell to do it on paper ( )]
Fa: they go start scribbling on the wall (and all over)
(0.8)
Dr: .hh thee— thee psychological testing (.) that was done here (0.3)
for her intelligence— .hh showed that although J's not a genius
(0.2) .hh [that] her intelligence (.) was (0.4) at (0.1) the lower
Mo: [no]
Dr: end of what we would consider normal intelligence
(0.8)
( ): ( )
Dr: And she does not appear to be a reTARded child (0.2) .hh ze zaying
well okay if she's not reta:rded (0.5) you know why th[e heck]
Fa: [ta— .hh]
Dr: i(.hh)sn't the kid talking.
(0.5)
Dr: .hh we also [don't have any] evidence that she has any hearing
Fa: [hhh .hh]
Dr: problems, her hearing seems to be fine so (0.2) sometimes you know
deaf children (0.4) don't talk (0.4) .hh (0.6) so: okay that's not
the problem well then w:hy (.) you know here she is (.) the other
kids are talking so you obviously you're doing something RIght (.)
cause your other kids are coming along=
Mo: =yeah=
Dr: =and learning .hh so then you say— what's wrong with J? If it's not
something wrong with YOU .hh uhm (0.5) J has (0.1) .hh a very
(0.3)
Fa: ((cough))
Dr: specific problem (0.4) with language (.) there is (0.1) .hh a special

148. part of the brain (0.3) which (0.2) has to do with la:nguage and
149. (0.2) .hh understanding what is said to you, and then s— getting out
150. the words, that you want to say (0.6) and for SOME reason or other
151. and I (0.5) cannot give you a good reason why this is so for J, .hh
152. (0.2) .hh in particular but for some reason this: (0.5) particular
153. thing that the brain does which is so important that we call
154. language, it is not doing well in J's case. And so (0.2) she has
155. great difficulty in understanding what is said to her and great
156. difficulty in getting the words out.

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