

Conversation Analysis and Ethnomethodology: the Centrality of Interaction

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INTRODUCTION

The conversation analytic perspective focuses on the moment-by-moment production of human social life. Conversation analysis (CA) affords a unique and powerful view of the ways in which people's vocal and nonvocal actions interlock in a temporal weave to generate organized patterns of interaction (Garfinkel, 1984[1967]; Sacks, 1992; Heritage, 1984; Maynard and Clayman, 1991). It allows us to see the deep and fine-grained organization of health care interactions, an organization that becomes part of the experiences of patients and health care providers.

This unique view is a function of the questions conversation analysts ask about health care interactions (as well as CA's theoretical assumptions). In this chapter, we discuss these distinctive questions and focus on two core aspects of the CA perspective: its emphasis on the social and the temporal nature of human interaction. We also discuss examples of CA research on health care interactions, giving special attention to the ways that 'practical epistemics' shape the opportunities for patients and health care providers to demonstrate their knowledge and experience to each other (Whalen and Zimmerman, 1990). Our aim is to show when and how CA can be useful to researchers who are interested in interaction in medical settings, doctor – patient consultations.

THE FUNDAMENTAL TEMPORALITY AND SOCIALITY OF INTERACTION

Conversation analysts who study medical interaction are interested in *what* goes on in these interactions and *how* this is achieved. Recognizing that talk-in-interaction is the means through which people achieve a wide range of social actions and activities, conversation analysts ask how participants in interaction organize their behaviour to accomplish actions and activities in the consultation.¹ What are the specific patterns of vocal and nonvocal behaviour through which health problems emerge in the consultation and are diagnosed, patients' and providers' roles are manifested, sustained, shifted and altered, and medical settings are accomplished? These questions lead conversation analysts to investigate and document the achievement of 'social facts' in the medical consultation – specifically, the practices participants use to produce (and show understanding of) what is going on in the interaction – as it unfolds over time, collaboratively and contingently.

Reflecting CA's roots in ethnomethodology (Garfinkel, 1967), conversation analytic studies of medical (and other) interactions focus on members' practices for achieving understanding with one another in the real-time flow of interaction. The researcher does not aim to uncover underlying meanings or intentions in talk: a conversation analyst relocates the 'problem' of understanding in interaction to its original domain – as a practical matter for the participants themselves to resolve, on a moment by moment basis, in every interaction. Schegloff and Sacks (1973) offered this rationale for approaching the 'understanding question' as a participant's issue:

We have proceeded under the assumption (an assumption borne out by our research) that in so far as the materials we worked with exhibited orderliness, they did so not only to us, indeed not in the first place for us, but for the co-participants who had produced them. If the materials (records of natural conversation) were orderly, they were so because they had been methodically produced by members of the society for one another, and it was a feature of the conversations we treated as data that they were produced so as to allow the display by the co-participants to each other of their orderliness, and to allow the participants to display to each other their analysis, appreciation and use of the orderliness (1973:290).

Here, a comparison with another tradition of research on medical interaction may be useful. In studies of medical interaction based on Interaction Process Analysis (e.g., Roter and Larson, 2002), researchers record interactions and then code participants' speech into content-based categories that correspond to the thoughts speakers are conveying with their utterances, and whether they signify task-oriented or socioemotional exchanges (e.g., Roter and Larson, 2002).² Understanding what participants meant and what actions they were doing is regarded as a researcher's task, to be approached by listening for cues in the content of their talk, such as speakers' tone of voice or intonation.³ Once the participants' utterances are categorized, the analyst can then determine, via quantitative analysis, whether there are patterns in the interactions that correspond to variables such as the participants' demographic characteristics (e.g., gender; Hall et al., 1994), or outcomes such as patients' satisfaction with their medical encounters (Roter and Hall, 1992). Researchers using this approach are fundamentally

concerned with those correlations and how information about them could be used to improve medical practice.

Conversation analysts approach the 'understanding question' differently, seeking evidence in the talk or other actions for how the participants orient to and understand each other. The rationale for this approach is that human interaction irremediably occurs in sequences of turns, over time.⁴ Every action in an interaction cannot help but follow some other action, and occur in its 'shadow' as it were. Likewise, each action cannot help but cast an interactional shadow on what is to follow. This inescapable temporality of interaction creates the conditions within which actions will be understood and within which each successive action will therefore be undertaken.⁵ Therefore, the positioning of utterances in the stream of conversation is a crucial *social resource* participants employ to make their utterances recognizable and to determine what actions co-participants are doing.⁶ As Schegloff (2007:8) explains, it is a resource for the analyst as well:

... we start from an observation about how some bit of talk was done, and ask: What could someone be doing by talking in this way? What does that bit of talk appear designed to do? What is the action that it is a practice for? We try to ground our answer to this sort of question by showing that it is *that* action which co-participants in the interaction took to be what was getting done, as revealed in/by the response they make to it.

When a patient responds to a doctor's utterance, he or she displays an understanding of it as an action (Sacks et al., 1974). The doctor then has to react to the 'public' sense of the initial utterance (Schegloff, 1992), and may confirm (or correct) that initial understanding (Schegloff and Sacks, 1973). The patient's reaction is therefore partially constitutive of what the original utterance comes to mean and do (cf. Mills, 1940). At an even more fine-grained level, recipients' reactions can affect speakers' utterances even as they are being produced (Reddy, 1979; Goodwin, 1979, 1980, 1981; Maynard and Perakyla, 2003). For example, a person (in the midst of hearing a speaker's utterance) might react in ways that cause the speaker to reshape, edit or delete parts of what he or she said or was demonstrably heading toward saying.

Certainly, when we speak with each other, the particular words we use shape the type of action we are thereby doing. But the *positioning* of an utterance and the recipient's reception of it also matters deeply for what it will come to mean and do in an interaction (Schegloff, 1993: 121). For example, consider the following from a clinic visit:

Example 1

(Gill and Maynard, 2006: 121–2)

[16:1032]

- 1 Dr: You mention some easy bruising? An bleeding?
Fatigue?
- 2 Pt: Yea::h. I- an the- an: that you know: has been
(.) most recently

- The privileging of the participants' displayed orientations to each others' actions in CA also precludes the lamination of theoretical assumptions onto the interaction, such as assumptions that all interactions are sites of class domination and that participants will adhere to social/institutional roles. Researchers

who work within the tradition of Critical Discourse Analysis focus on the way interaction is shaped by 'macro' social arrangements. Doctors' and patients' socialization within their culture(s), the roles, ideologies, attitudes, values, and bodies of knowledge they have learned and internalized, and their institutional prerogatives (such as power and authority) are thought to affect 'micro' level interactions.⁷ This follows Weber's (1949) insight that subjective meanings influence behaviour, and incorporates Parsonian (1951) theories on the impact of norms, values, and social roles in particular on human behaviour. For example, Fisher (1983) and Todd, (1983), having observed that doctors tend to support the status quo and patients often accept medical definitions (even when they are not in their best interests), argue that doctors' and patients' socialization has provided them with these orientations. They contend that 'the medical event becomes much more understandable when relations among abstract worldviews, more concrete structural and organizational contingencies, and medical discourse are considered' (Fisher and Todd, 1983: 7).

The fact that researchers in the Critical Discourse Analysis tradition draw upon theory to make sense of interaction is a function of their research interests: fundamentally, they seek to understand *why* participants in medical interactions behave the way they do. In a CA study, to draw upon theory to interpret why participants behave as they do would displace and preclude the work of discovering *what* they do and *how* it is done. Because of this orientation, the CA approach is a powerful means of understanding the very generation of social arrangements that Critical Discourse Analysts use as explanatory resources: asymmetric social relationships, rights and obligations, power, and authority (Wetherell, 1998, Schegloff, 1997).

Consider the following extract from an interaction between a primary care physician and patient. Some researchers might seek to explain the participants' behaviour, by considering how their actions are influenced by factors such as their respective beliefs, understandings, and knowledge, which were themselves products of their gender role socialization (the doctor and patient are both female), their institutional statuses (patient, doctor), and so forth. In contrast, when employing CA, one's focus shifts from explaining *why* to understanding *what* and *how*. The analyst focuses on documenting how speakers organize their utterances and embodied actions (such as gestures, gaze, and posture) so that recipients will understand (1) what speakers are doing and (2) why they (recipients) are being invited, compelled, allowed (etc.) to do in return. Therefore, the specific focus is on the endogenous organization of the interaction itself, especially the fundamental social resources – such as the positioning of utterances in the stream of conversation over time – that the participants use to make their actions recognizable and understandable to each other.

Prior to the exchange the patient reported having dry skin on her face. The doctor examined her and suggested it could be due to 'sun damage'. The patient countered, reporting that she did not get very much sun exposure, and speculated whether it could be related to working in front of a computer or to 'age'.

Claiming not to know what she was looking at, the doctor offered to refer the patient to a dermatologist and after some ensuing talk about dermatological procedures, the doctor turned towards her desk and began writing in the patient's chart. It is at this moment that the patient raises the matter of the relationship between dry skin and hormones (lines 1–4). We will focus on just a few key features of the practice she uses to raise the explanation and what ensues, to illustrate what the CA approach can yield.

Example 2

(Gill and Maynard, 2006:129)

(12) [9:539]

- 1 Pt: The only thing I was wondering if dere
is .hhhhh you kno:w
- 2 ah::n (2.0) ((doctor turns from desk to look
at patient))
- 3 hormone deficiencies or something like this
that it (0.6)
- 4 (>°you know°<) that dries your skin out too.
(0.5)
- 6 Dr: °Mm°
- 7 (0.5)
- 8 Dr: Tch .hhh ah:m
- 9 (0.8)
- 10 Pt: Or no[t too much
- 11 Dr: [tch There are some hormone problems like thyroid
12 p[roblems]=
- 13 Pt: [°Mm hm°] ((nodding))
- 14 Dr: =which can do tha:t. Um we've never found that
(.) on you
- 15 before.

While the non-fluent nature and general discontinuity of the patient's turn at lines 1–4 might seem to indicate that she is unsure of herself or hesitant about what she is saying, (and perhaps intimidated by the doctor's authority), upon closer inspection, one can see that the patient designs her turn in a way that invites the doctor to attend to her. The doctor is facing the desk, writing in the patient's chart. The patient begins her utterance by proposing that she has a question to ask: 'The only thing I was wondering if dere is', and at the precise location where she could be expected to produce the topic of her inquiry, she delays the continuation of the turn by taking a long inbreath, saying 'you kno:w ah::n', and pausing for two seconds. The doctor abandons her writing and turns to face the patient. Thus, features of the patient's turn that might seem to be evidence that she is following the traditional (i.e., submissive) patient role, can be understood in terms of what they accomplish as actions: they attract the doctor's attention away from writing and on to the patient (Goodwin, 1980, 1981).

Having obtained the doctor's attention, the patient continues with her turn. As a whole, the turn is a speculation about the relationship between hormone problems and dry skin: the patient asks whether hormone deficiencies exist that dry 'your' skin. By structuring it this way, the patient offers the doctor an opportunity to respond to it as a generic (i.e., hypothetical) question and tell her whether dry skin can ever be related to hormones. However, by placing the speculation within an environment where they have been considering possible causes for the skin problem, the patient provides for it to be heard as a candidate explanation for *her own* skin condition. She thus gives the doctor an alternative option: to respond to it as a nongeneric question and to address the issue of whether *she* has hormone problems that could be causing the dry skin. Using this practice, the patient cautiously invites the doctor to explore a potential explanation for the skin problem (Gill and Maynard, 2006).

At a point where it would be relevant for the doctor to respond to the patient's speculation, there are a number of features (such as silences) that serve to delay the production of a response (lines 5–9). The patient demonstrably treats the delay as a harbinger of *disagreement*. Evidence for this claim can be found on line 10, where the patient modifies her speculation with 'or not too much', a move that may make it possible for the doctor to produce an agreement (Pomerantz, 1984a; Sacks, 1987). Here we see the crucial role of temporality in interaction as well as the impact of recipients' responses on speakers' in-course actions; participants themselves treat the timing of recipients' responses (e.g., whether they occur immediately or not) as a resource for gauging their likely reactions, and they may backtrack on a stance, shore up a claim, and in other ways modify the actions they were in the midst of doing and thus change the response implications for the recipient even as he or she is in the midst of responding (Pomerantz, 1984a, 1984b).

In partial overlap with the patient's modification, the doctor initially responds to the patient's speculation as if it were a generic question about the possibility that hormone deficiencies could cause dry skin. She confirms that it is possible, citing an example of a hormone problem that could cause dry skin ('There are some hormone problems like thyroid problems which can do that:'). However, the next component of the doctor's turn treats the patient's speculation as nongeneric. She responds as if the patient had implied that she might have hormone deficiencies herself, and that they could be causing the skin problem: 'Um we've never found that (.) on you before'. Note that the doctor never officially asserts that hormone problems *are not* causing the patient's dry skin. Rather, by 'citing the evidence' (Maynard, 2004) that previous lab tests have not revealed hormone problems, she invites the patient to hear it as an unlikely possibility in her case.

By giving detailed attention to the particulars of the talk and other behaviour in this interaction, we see how the patient exhibits agency in directing the doctor's attention to a potential cause for her skin problem, and how the doctor manages to cast it as unlikely without dismissing it entirely. By focusing on the

endogenous organization of such interactions we can begin to see how the 'social fact' of a medical diagnosis emerges from the moment-by-moment actions of the doctor and the patient. In the next section, we discuss how attending to the participants' orientation to each other's epistemic rights and responsibilities provides a fine-grained understanding of asymmetry and 'authority' in health care encounters.

THE SOCIAL EPISTEMICS OF KNOWLEDGE, EXPERIENCE AND SENSATIONS

By attending to the particulars of the talk and other behaviour, CA reveals how patients and doctors interactionally manage central issues in health care (Beach, 2005; Boyd, 1998; Greatbatch et al., 1995; Haakana, 2001). In and through these discussions they also manage who has what rights to make what sorts of medical assertions. Given CA's emphasis on participants' activities and how they are jointly produced, it might seem surprising that conversation analysts would investigate topics such as knowledge asymmetries in medical encounters. The surprise would be justified if CA researchers treated knowledge as an external factor that affected interaction, as in numerous studies of asymmetry in medicine (e.g., Tannen and Wallat, 1986; Paget, 1983; Cicourel, 1983). Drew (1991) notes that in these studies:

... the analytical dimensions associated with asymmetry of knowledge in institutional settings appear to be that by virtue of exogenous factors, participants do not share access to the same body of knowledge; and because that knowledge is consequential for some decision or outcome, this works to the disadvantage of the one who does not have access to it. And the communicative effects of such asymmetries are detected by the analyst locating instances of the participants' mutual incomprehension, even though they may have been unaware at the time of such breakdowns (Drew, 1991:25).

However, the CA approach treats knowledge itself as a social phenomenon. As Drew explains, conversation analysts examine how participants *orient to* what they 'know' in interaction with one another. This reveals the social (i.e., *interactional*) genesis and management of knowledge and knowledge asymmetries:

Where ... one is put at some disadvantage by the other, that is achieved interactionally. Furthermore, the ways in which knowledge asymmetries are consequential for conversational interaction arise from speakers' orientations to such asymmetry. Thus we are looking for ways in which asymmetries of knowledge are demonstrably relevant to the participants in the design of their talk (Drew, 1991:26).

When using this approach, the analyst focuses on the orientations towards knowledge that the participants display to one another (rather than on their 'cognitive states'). Participants' public displays of knowledge (and the *grounds* for their knowledge) are consequential for their interactions with one another, and these are not equivalent to the type and amount of knowledge they 'actually' have (cf. Wittgenstein, 1953, 1958).

In addressing the question, 'what is causing the patient's illness?' during the medical visit, participants display an orientation to a set of rights and obligations in regard to knowledge. Conversation analysts have investigated how patients and physicians orient to the boundaries of their respective 'legitimate' realms of knowledge regarding their bodies and medicine (Drew, 1991; Gill, 1998, 2005; Gill et al., 2001; Gill and Maynard, 2006; Maynard, 1991; Pomerantz et al., 2007).

For instance, consider Maynard's analysis of the perspective display series in clinical interactions. A physician, about to give parents bad news regarding the cognitive testing of their child, starts by asking them, 'What do you see as – as his difficulty?' (Maynard, 1991: 468). As Maynard points out, this move by the doctor operates as a 'perspective display invitation', and gets the parents to offer an assessment of their child to which the doctor can respond, and in responding, tailor the specific delivery of diagnostic news. Note that this method of 'setting up' the delivery of diagnostic news allows the news delivery to incorporate aspects of the parents' view, knowledge and experience. The doctor's professional epistemic authority is not simply asserted over the parents' knowledge and experience, but, as much as possible, is tailored to it (Maynard 2003). Thus one way professional epistemic authority is asserted and sustained is to fold into it (as much as possible) lay experience and expertise. This relationship between professional and lay bases of knowledge regarding health and illness is more refined and subtle than theory would predict, and can only be elucidated via detailed analysis of the participants' own displayed orientations during actual health care interactions.

Similarly, conversation analysts have investigated how patients (or their surrogates, such as parents of children) orient to boundaries regarding their rights to ask for medical services, and to disagree with professional medical advice (Costello and Roberts, 2001; Gill, 1998; Heath, 1992; Stivers, 2005a, 2005b, 2006, 2007). For example, in an analysis of how parents sometimes resist doctors' treatment recommendations, Stivers (2005b) shows that the predominant methods of parental resistance are quite subtle and indirect, e.g., withholding acceptance of the doctor's advice (2005b). Through this indirect mode of resistance, parents simultaneously pay deference to the professional authority and expertise of the doctor, while exerting their own authority, (as parents), implicitly to pass judgment on the acceptability of the advice.

Returning to Example 2, note that when the patient invites the doctor to explore a candidate explanation for the skin problem (lines 1–4), she treats the potential causal link between hormone deficiencies and dry skin (as well as the actual causal link between hormone deficiencies and *her* dry skin) as things the doctor has both the right and the obligation to know about. The doctor also orients to this right and obligation. However, there is another side to the practice the patient employs, which is part of the unique texture of doctor–patient interaction made visible by CA. When patients make such inferences (rather than forthright claims) about what causes their illnesses, they can safely direct their doctors' attention

towards diagnostic possibilities, and simultaneously exhibit attention to the logic of medical inquiry (Gill, 1998). It is CA's focus on sequences of action – attention not only to the actions utterances themselves do, but also to what responses they call for or permit in return, and how these responses figure in the very constitution of actions *as, recognizably, particular actions* – that permits such findings.

Another outcome of CA investigations into asymmetries of knowledge is the finding that they are not always tipped 'in favour' of the doctor. Both doctors and patients treat the latter as having the right and the obligation to know about their personal health experiences – how they feel, where pains and other sensations are located, when they began, and the like, a realm that doctors can only access via their questions (Boyd and Heritage, 2006; Drew, 1991; Gill, 1998; Halkowski, 2008; Heritage and Robinson, 2006; Gill et al., 2010). Through patients' reports of their symptoms (Halkowski, 2006; Heritage and Robinson, 2006), doctors' questions and patients' responses (Boyd and Heritage, 2006; Halkowski, 2008) and other interactional practices, participants display and draw upon patients' license to make particular assertions and observations about their own bodies.

However, the 'license' patients have to own and report their bodily experiences is still itself subject to social (i.e., interactional) management, and patients do extensive work to show that they are responsible and appropriate experiencers of their bodily sensations (Hilbert, 1984). For instance, when patients narrate to their doctor the discovery of new symptoms, they regularly do so in a manner that casts the symptoms' discovery as 'unmotivated', 'accidental', or 'out-of-the-blue', while simultaneously conveying the sense that they were appropriately monitoring their own health (Halkowski, 2006: 110–111). Through these two aspects of patients' narratives of new symptom discovery, they display themselves to the doctor as 'reasonable patients' (neither excessively attentive nor inattentive to bodily sensations). This analysis of patients' new symptoms reports thus helps to reveal the interactional bases for a 'social epistemics of sensation' (Halkowski, 2006:110).

The interactional practices through which these rights and obligations to knowledge, experience, and sensation are managed are the very practices that serve partially to constitute our sense of institutional identities such as 'doctor' and 'patient'. This is part of the interactive work through which these identities emerge or come into view (Hilbert, 1981, 1992; Halkowski, 1990; Zimmerman and Boden, 1991). These interactional practices are also, then, partially constitutive of the institutional setting: 'a clinic', 'a hospital', etc. (Drew and Heritage, 1992). A primary focus on people's activities in interaction, including their precise temporal details, gives us a deeper view into the social constitution of things we might otherwise theoretically reify or essentialize (Pollner, 1979, 1987; Maynard and Wilson, 1980).⁸

The foregoing examples of CA research on health care interactions demonstrate some of the characteristics of the approach which make it especially useful to those who wish to address policy, management, and professional practice

questions in health care. CA focuses on the actual, moment-by-moment production (by providers, patients, family members, and others) of health care interactions. This focus on people's actual interactive practices and behaviours allows the researcher to make discoveries that might not be anticipated (or demanded) by theory, ideology, or even common sense. Thus, the sorts of research questions for which a conversation analytic approach is best suited are those that have at their centre a concern with how some actions or sequences of actions *actually unfold* in health care interaction. For example, CA provides a means to discover how health care policy is being implemented in practice, during interactions between medical professionals (Boyd, 1998) and between clinicians and patients or their parents (Pilnick and Coleman, 2003; Butler et al., 2010). It can uncover the dynamics involved in negotiations surrounding sensitive issues such as HIV status (Kinnel and Maynard, 1996), difficult diagnostic news (Lutfeý and Maynard, 1998), genetic abnormalities (Pilnick, 2002), lack of physical competence (Parry, 2004), and the management of chronic illness (Lutfeý, 2004).

Nevertheless, some of the most profound studies started with no particular practical or programmatic question in mind. Instead, they started with the motivation to investigate how some aspect of health care interaction occurs, thus holding back from any commonsense presumption that we know what parts of health care interactions are deep, interesting and important. These presumptions short circuit analysis, and can prevent us from making discoveries that change our understanding of health care processes. They can also prevent us from learning how the participants address interactional problems. Indeed, before some CA studies of health care were initiated, there was no sense or hunch that a particular solution to a problem was nesting in some quiet corner of these interactions. These participant-generated solutions can be deeply instructive for health care providers and those who are involved in physician education and training, as well as patients and their advocates.

For instance, the series of studies of clinicians' descriptions of what they are seeing, hearing, or feeling during physical examinations started from no particular *practical* problem or question, but simply from an interest in what sorts of talk and action physicians engaged in the midst of physical exams (Heritage and Stivers, 1999; Stivers, 2005a, 2005b, 2006, 2007). With that focus, the researchers uncovered what turned out to be a rather powerful tool for the very important practical problem of how to lessen the number of unwarranted prescriptions of antibiotics (see Stivers, 2007).

CONCLUSION

In this chapter, we have focused on two foundational aspects of conversation analysis, and have shown how they inform CA research on doctor-patient encounters. First, for interaction to be deeply understood, we must give sharp attention to its irremediably temporal character – the fact that every action occurs

in the flow of time, following some actions and preceding others. That actions occur in temporal sequences fundamentally shapes the character of each and every act. The second foundational aspect we have focused on emerges from the first: every action in human interaction is profoundly social. As Volosinov puts it:

The stylistic shaping of an utterance is shaping of a social kind, and the very verbal stream of utterances, which is what the reality of language actually amounts to, is a social stream. Each drop of that stream is social, and the entire dynamics of its generation is social (Volosinov, 1973: 93–94).

Interaction is more than a conduit for information and more than a mirror upon which larger social dynamics are reflected. If one uses a conversation analytic approach, each action in the interaction becomes a potential phenomenon for detailed analysis. By *exploring* these phenomena we can illuminate social processes in health care that might otherwise go unnoticed. Such a perspective is vital if we want to analytically recover how each (always contingent) aspect of health care interaction is generated, maintained, and changed. By attending closely to features of the interaction itself – investigating the social practices the participants use to achieve their actions and activities – we can gain a much deeper appreciation of health care delivery.

NOTES

1 This insight was pioneered by a number of scholars, most prominently Mills 1940, Wittgenstein 1953, 1958, Austin 1962, and Sacks 1992.

2 'Interaction process analysis' is a method of coding interaction originally developed by Bales (1950) to code behaviour in small groups and later adapted to the study of doctor–patient interaction (see Heritage and Maynard, 2006).

3 For an example of the types of behaviors coded by researchers using the Roter system, see: www.acgme.org/outcome/downloads/landC_9.pdf.

4 A fascination with temporality has possessed philosophers for ages, and a few scholars of interaction and communication have been equally possessed by it, puzzling over its implications. See Augustine's *Confessions* (Book 11, Chapt 27). Cf. W. Ong, 1967, 1969, 1982.

5 Stanley Fish persuasively argued that readers make sense of texts in a similar fashion. In the midst of reading, the reader makes a provisional sense – a sense that the very next sentence, clause or word might adjust, alter or completely undercut (Fish, 1997[1967]: 23, 30–34).

6 The insight that participants in conversation make and derive meaning from the positioning of utterances was crucial to the work that Sacks, Schegloff, and Jefferson did in their initial investigations into the organization of human interaction (Sacks, 1992; Schegloff, 1968; Jefferson, 1973). As Rawls put it:

... The ordering features of talk – the placement of utterances – is a huge and essential tool that people use to render their 'thoughts' in a mutually intelligible form. And they never manage this without having the sequential back and forth character of interaction change what they mean. That is, what they will have meant in the end, even to themselves, will be what emerges from a collaborative sequential production, not what they thought they meant before the sequential series was produced (Rawls, 2005: 175).

7 Heritage and Maynard (2006) call this tradition 'microanalysis', and note that it was also inspired by the Chicago School of ethnography and pioneering studies of professionalization within

medicine (e.g., Freidson, 1970); it includes the work of researchers such as Fisher, (1984), Mishler (1984), Todd (1989), and Waitzkin (1991). By contrast with this work, for review articles on CA studies of medical interaction, see Heritage and Maynard (2006b), Maynard and Heritage (2005), Pilnick, Hindmarsh and Gill (2009), and Halkowski (forthcoming).

8 CA takes a unique 'field' perspective towards interaction, rather than a perspective that would privilege the 'objects' in the interactional field (McDermott and Baugh, 1992; Halkowski 1992, 1999). This is the logical outgrowth of Goffman's (1967: 3) statement of the need to make interaction *itself* our analytic focus: 'not, then, men and their moments. Rather, moments and their men'.

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