Maximising agreement in naturopathic consultations: Doctors’ displays of involvement and affiliation in response to patients’ narratives

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1. Patients’ elaborations and doctors’ responses: Overview of previous research

A large number of studies on doctor-patient talk have focused on the institutional asymmetry characterising doctor-patient interaction and have dealt with data in which the institutionality of talk is embodied first and foremost in its form, most notably in turn-taking mechanisms which depart from the way in which turn-taking is managed in ordinary conversation. These studies have highlighted, among other things, the overwhelming tendency of doctors to ‘silence’ patients. For instance, Beckman and Frankel (1984) found that physicians prematurely interrupt patients’ problem presentations in order to progress to the information gathering phase of the medical interview¹, and West (1984: 58) noted that doctors “systematically and disproportionately” interdict patients’ contributions. According to West (1993) and Frankel (1990), the turn-taking system of doctor-patient talk is rigidly organised with respect to speaker identity. This rigid organisation of turns is accounted for in terms of the specific activities performed and tasks accomplished in the medical interview. In

¹ Medical interviews are usually divided into six phases, or stages. These are: (1) relating to the patient; (2) discovering the reason for attendance; (3) conducting a verbal or physical examination or both; (4) considering the patient’s condition (i.e. making a diagnosis); (5) detailing treatment or further investigation; and (6) terminating. What is referred in this paper as ‘problem presentation’ and ‘information-gathering’ roughly correspond to (2) and (3) respectively. For further details on the canonical organisation of the medical interview see Byrne and Long (1976) and ten Have (1989).
particular, in the investigative stage of the interview (most commonly referred to as history-taking) the interaction unfolds through a series of questions and answers that are sequentially chained. According to Frankel (ibid.), this attributes a ceremonial character to a speech exchange system where the questioner (the doctor) recurrently imposes upon the answerer (the patient). This idea is consistent with much doctor-patient interaction literature, in which the patient is often seen as a passive recipient of doctors’ initiatives, (see for instance Mishler, 1984; West, 1984a). Hence, although doctors’ questions are designed to elicit information from the patient that may be relevant for the management of her/his medical condition, they are also constructed in a way that discourages any elaboration on the patient’s “lifeworld” concerns (cf. Mishler, 1984) and favours minimal “no problem” responses (cf. Sacks, 1987; Heritage and Sorjonen, 1994). During history-taking, patients’ immediate and minimal answers, not just to yes/no-questions but also to wh-enquiries, guarantee adherence to the medical agenda. The need for immediate and minimal responses is made even more compelling by the line of questioning, which can evolve into a ‘build-up’ of lexical items referring back to an initial question, the series of questions thus shaped having a clear ‘checklist status’.

Contrary to what has been reported so far, a more recent study by Stivers and Heritage (2001) shows that on a number of occasions the patient volunteers more information than is requested by the physician. Patients’ elaborations are essentially of two kinds and can have various functions. Stivers and Heritage draw a first distinction between expanded answers and full-blown narratives. Expanded answers can be used to perform three main tasks: addressing difficulties in responding, supporting responses by adding details, and pre-empting negative inferences. Unlike expanded answers, what Stivers and Heritage (2001) call full-blown narratives or narrative expansions present information that is “neither licensed by a question nor does it expand on an answer” (ibid.: 165). Instead, they address concerns that patients independently treat as issues to be acknowledged and place doctors in the role of story (or trouble) recipients², moving away from the interactional organisation of history-taking (and medical interviews in general) and closer to that of everyday conversation. What is of interest for the purposes of the present paper is to note doctors’ responses to patients’ elaborations, whether they are expanded answers or narrative expansions. In their single-case analysis of a primary care encounter between a male doctor and a female patient, Stivers and Heritage

have observed the doctor’s failure to provide responses invited by the patient’s elaborations and recurrently projected by similar elaborations in ordinary conversation. Instead, the doctor produces minimal acknowledgment tokens and, at points, even disregards the patient’s elaborations by looking away, trying to shift the focus back to the routine activity of history-taking. To do so, he continues his questioning shaping his enquiries in a way that discourages the patient from pursuing her agenda of concerns.

The findings of Stivers and Heritage are confirmed by Jones (2001), whose analysis is based on the data-gathering portion of 25 videotaped interviews between general practitioners and their patients. Overall, the author finds that physicians remain silent or produce minimal acknowledgment tokens in response to patients’ answers to their questions, noting a substantial absence of so-called assessments, which in everyday conversation are often employed as displays of alignment, affiliation, and support. Specifically, Jones (ibid.) points out that in offering speakers’ interpretation of some previous conversational object, assessments display analysis of ongoing talk. Moreover, they convey an evaluative orientation, elicit responses from co-participants, and can accomplish a number of social actions (e.g. complaining, insulting, praising, etc.). Assessments can occur at various points in a conversation. Typically, as pointed out by Maynard (1997), they follow informing acts and are employed by participants to converge on newsworthiness and valence, i.e. to “achieve accountable (mutually visible and oriented-to) good or bad news” (ibid.: 123). In troubles-talk and storytelling, assessments can be used to express support (e.g. empathy, encouragement, etc.) after some troubles-telling, thus aligning as a recipient, or they can be used after a story’s punch line to signal understanding and appreciation of preceding talk. Overall then, assessments are widely-used interactional devices aimed at sustaining social solidarity. As mentioned above, however, Jones (2001) finds that such a precious resource is rarely employed by doctors when interviewing their patients. A possible reason for this can be the fact that doctors have traditionally been trained to appear as objective professionals withholding “expressions of surprise, sympathy, agreement, or affiliation in response to lay participants’ describing, claims, etc.” (Drew and Heritage, 1992b: 24). This long-flaunted neutrality has also always been one of the main concerns of the teaching literature in the field of medicine, which has focused on how to train doctors to gather accurate data about patients’ thoughts and feelings, by carefully listening to them (and letting them know that they are being heard), while at the same time refraining from expressing personal opinions and emotions (cf. for instance Coulehan and Block, 2001: Chapter 2).
According to Jones (2001: 141), another possible explanation can be found in external factors, specifically time constraints: given the average length of a medical visit (fifteen minutes in the United States), it is understandable for doctors to follow a line of questioning, formulate a diagnosis, and establish a treatment plan in the time available trying not to get “side-tracked” by talk concerning patients’ personal stories (ibid.).

Contrary to Stivers and Heritage’s (2001) and Jones’ (2001) findings, in section 3 of the present paper we will see that doctors’ assessments are not always missing. We will do so by looking at a long storytelling sequence taken from a naturopathic interview, which in turn belongs to a sample of naturopathic consultations collected at the University of Bridgeport Naturopathic Medical Center (Bridgeport, Connecticut). Before moving to the discussion of data, however, a few general observations on the practice of storytelling are in order.

2. Notes on storytelling

One of the main tenets of conversation analysis is that conversation is made an observably orderly phenomenon by the mechanism of turn-taking (cf. Sacks et al, 1974). The turn-by-turn organisation of conversation can be best appreciated by looking at long sequences of talk, such as the one analysed in this paper. The investigation of a long sequence of talk taken from a naturopathic consultation has made it possible to observe how patient’s initiatives and doctor’s responses to these initiatives interact over a long stretch of the interview, providing for an overall textual and rhetorical orderliness of the interaction. A specific type of sequence will be discussed in this paper, namely storytelling.

Storytelling is an interactional achievement, in that it needs someone to play the role of teller, but also someone else aligning as recipient. Stories involve an extended holding of the floor, but they are not merely narratives, i.e. a “recital of events and circumstances” (Polanyi, 1985: 189). Rather, they have to communicate a message that is relevant outside the storyworld, particularly to the interaction between story-teller and story-recipient and their situated talk. Relevance to the preceding and following talk, and to the participants’ lifeworld in general, is ordinarily condensed in a moral, i.e. the point the teller tries to

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3 In fact, as pointed out by Jefferson (1978: 245), a story is rarely (if ever) a block of talk, rather it is made of segments in which teller’s talk alternates with recipient’s talk.
make or the maxim s/he tries to illustrate through the telling. The moral is a recognizable ending format, which invites agreement or disagreement from story-recipients and provides for the resumption of the normal turn-taking machinery (cf. Levinson, 1983: 324).

Storytelling imposes some constraints on both story-tellers and story-recipients. A good story-teller will use appropriate linguistic devices to evaluate the circumstances s/he is describing, thus enabling the hearers to recover the gist of the story. This can be done via assessments, which, as stated by Goodwin and Goodwin (1992: 155; cf. also section 1 above), involve taking up a position towards the event or entity being assessed and displaying the utterer's experience of that event, including her/his affective involvement in it. When the telling recognizably comes to an end, recipients have to demonstrate that they have understood the point of the story and that they either agree or disagree with the teller (cf. above). The unmarked, or ‘preferred’ (cf. Levinson, 1983: 336; Pomerantz, 1984b), response to a story is agreement. Agreement is produced by recipients upon story completion and often takes the form of assessments, or second assessments (if the teller has already formulated her/his own assessments; cf. Jefferson, 1978; Pomerantz, 1984b; Goodwin, 1992).

Another way to show agreement with the point is a second story (cf. Sacks, 1992a, 1992b; Ryave, 1978). Second stories show that storytelling is an interactional business, as they are naturally produced by recipients who are reminded of their own experiences during the telling of first stories, and use second stories primarily to show understanding of, and often agreement with, first stories. ‘Second’ is a technical term in various respects. A first aspect that can be noticed concerning the relationship between first and second stories is that they are sequentially adjacent. In other words, a second story is told within “conversation time” (Sacks, 1992b: 7), i.e. it is spoken out immediately after the first. Moreover, a second story is topically coherent with the first that gets told. Thus, if the first story is about someone achieving something extraordinary, like for instance winning an international competition, the second story will also be about victory or success (cf. Sacks, 1992b: 3ff.). Another key element is the selection of characters, in that a second story will have the same kinds of characters as a first story. So, if the teller of the first story is the winner of the international competition that s/he is telling about, the teller of the second story, i.e. the recipient of the first, will also have to be the winner in her/his own story. Hence, not only does the second story-teller construct her/his story by reference to the first story, but also by reference to what the first story-teller did in the first story, thus making the second story interactionally relevant. Recounting a
similar experience seems to be the easiest way to show understanding and agreement, i.e. ultimately what second stories are supposed to do. Should a teller of a second story fail to make the characters of her/his story fit those of the first, then there would be no point in telling a second story. This presupposes active listening on the part of the teller of the second story, who has to monitor the first story to produce a matching telling, as we will see in section 3.

3. Responding to patients' narratives: Doctors' assessments and second stories as a resource for 'premature' advice-giving

In section 1 we have seen that doctors may resist patients’ elaborations during history-taking to pursue the medical agenda of the visit. Generally speaking, the goal-oriented nature of the medical encounter, and the task-related character of all its different stages (not just history-taking), require doctors and patients to cooperate in shaping their roles and activities. In some cases agreement on the nature of the roles being played and the activities being performed requires a lot of interactional work. This happens when one participant is not aligned with the main activity warranted by the current interview stage (e.g. information-gathering during history-taking and physical exam, or advice-giving during advice and treatment, etc.), therefore causing agenda mismatches.

In what follows we will see how advice, which is commonly perceived as closing implicative (cf. Jefferson and Lee, 1992), may be resisted for its prematurity, regardless of the quality and applicability of the advice itself. Specifically, we will see how patients may ‘uncooperatively’ remain silent after advice given by doctors at an early stage of the consultation, i.e. during the information gathering portion of the interview (rather than during the advice and treatment phase; cf. note 1). As mentioned in section 1, during this stage of the medical encounter patients frequently provide lengthy elaborations on their answers, often disclosing sensitive information about themselves or giving voice to their thoughts and feelings about specific situations in their lives. Advice given by doctors during this stage may lead patients to think that they are being cut short, and is therefore likely to be resisted. Faced with this resistance, doctors may have to work hard on seeking agreement on the piece of advice they are trying to give. One possibility to do that is to respond to patients’ narrative expansions with second stories (cf. section 2), which, by recategorising patients’ own narratives (i.e. giving interpretations by accentuating certain features,
placing others in parentheses, creating new relations between the narrative components, etc.), essentially co-implicate their views as co-authors of the advice-giving sequence, ultimately making advice more acceptable.

The following excerpt, which has been divided into seven smaller fragments numbered from 1a to 1g for ease of reference, is an example of a series of stories. The only interactants for the entire duration of the recording are a male ‘primary’ (i.e. a fourth-year student clinician, indicated as PR in the transcript) and a female patient (P). They are not meeting for the first time here, as she has been a patient of the clinic for over two months and the primary has been her doctor ever since. The patient’s main problem is weight gain. The excerpt is preceded by approximately forty lines in which the primary enquires about the patient’s physical exercise in the previous seven days, and the patient explains that she has walked on three occasions and has also attended three classes of yoga. In excerpt 1a P engages in a narrative expansion, in which she volunteers information on how yoga helps her to feel better.

Excerpt 1a

201  PR how do you feel after? after that after yoga how do you
202  [(slb) after walking.]
203  P  [  d- after yo ga  ] i feel, hhh gosh! there’s no drug that
204   it can be the way yoga it is.
205  PR   uh huh.
206  P  not that i have experienced any drugs like :that [but he]
207  PR                                                   [uh hhh]
208  P  ((PR smiles while writing on chart)) he .hhh erm
209   (0.8)
210  P  it’s very relaxing very,
211   (1.1)
212  P  i didn’t go for the spiritual or meditative,
213  PR   uh huh.
214  P  purposes.
215  PR   [uh!]
216  P  [but] it happens anyway.
217  PR   it happens yeah.
218   (0.4)
219  P  [yeahh,]
220  → PR   [ and  ] how what do you think of that? did it help
221   with [((“this slb slb“))]}
Excerpt 1a starts with PR asking P how she feels after yoga and walking. P replies that yoga is better than any drug and clarifies the comparison by adding that it is very relaxing. This statement is followed by a pause of over one second (l. 211) whose function could be twofold. On the one hand, it may signal on-line processing, as P might be looking for the right word to complete the utterance in line 210 with another adjective (this interpretation could account for the repetition of “very”). On the other hand, however, the pause may also indicate that she is waiting for a second assessment on the part of PR to confirm her own evaluation. Since the clinician fails to produce a second assessment, P expands further on her answer. She says “I didn’t go for the spiritual or meditative purposes. But it happens anyway.”, which is met with a continuier (“uh huh.” in line 213), a newsmark (“uh!” in line 215), and a repetition claiming agreement (“it happens yeah.” in line 217)⁴.

In line 220 PR elicits additional information from P regarding the way yoga helps her from the meditative point of view. This kind of inquiry into the patient’s views and opinions has an interactional significance, in that, as will be clear from the discussion of this long sequence, by triggering P’s expansions, it contributes to a shared understanding of the tasks performed during the interview, and it also contributes to maximise agreement, working towards establishing a “mutuality of perspective” (cf. Maynard, 1991: 466). The patient replies affirmatively to the

clinician’s yes/no question in line 220 and the primary provides the positive evaluation remark “good!” (ll. 223). P then elaborates her answer and PR reiterates his positive assessment (ll. 224 and 225 respectively). After hesitating for a short while (ll. 226-229), P initiates a story that substantiates what she has just asserted. The telling opens with a statement that is also the point of the story (“uh the: concept that it’s you know, mostly in your mind it’s all mental.”). This assertion is what Ryave (1978: 127) has called a *significance statement*, i.e. a statement, with which the story culminates and in which it is condensed, that is also variously ‘recycled’ for subsequent versions of the story itself and for recipient’s second stories. As can be noticed from reading the excerpt, the reformulations of P’s general statement in lines 230-32 provide for the global coherence of the entire excerpt. This is achieved particularly through the use of repetitions as lexically cohesive devices, the reiterated words belonging to the same semantic fields, i.e. revolving around the same idea of achieving one’s goals by using the power of the mind (“mind”, “mental”, “mentally”, “goals”, “accomplishment”, “successfully”, “powerful”, etc.). These key concepts are not introduced in line 230 for the first time, as shown in excerpt 1b, which is taken from a preceding portion of the interview.

Excerpt 1b

109   P i was working on, looking at myself.
110       (1.1)
111   P and (look) just,
112       (0.9)
113   P straight at me and trying to: (. ) visualize that,
114       (2.5)
115   P erm impression of myself to be,
116       (0.4)
117   P better.
118   PR uh huh.
119   P erm
120       (0.8)
121   P and i think i: got there. “almost there“.
122   PR good.
123       (0.7)
124   PR good.
125       (0.4)
126   PR good.
127       (1.3)
Here P is talking about the work she has been doing and the results she has obtained in trying to improve the impression she has of her physical appearance (ll. 109-21). PR, after praising P’s results (122-26) and acknowledging the difficulty of the task (ll. 128-29) – a point that he will resume later in the
interview – is trying to focus P’s attention on the power of the mind by drawing on P’s personal experience (ll. 131-42). In this respect, the patient’s story starting in line 230 of excerpt 1a is a reformulation and reinforcement of the primary’s statement in line 140-42 of excerpt 1b. Interestingly, this use of storytelling bears a striking resemblance to the way this type of conversational resource is used in psychotherapy, where narratives may signal clients’ uptake of therapists’ formulations (cf. among others Bercelli et al., 2005; Rossano et al., 2003).

Having highlighted the power of the mind in achieving goals, the primary moves on to give advice to the patient (ll. 146-57). He does so by addressing her with imperatives (“keep working …and getting”) encouraging her to stay focused on her goals (“where you wanna be. how you wanna look.”, “how you wanna stand.”, and “how you wanna present yourself.”). His suggestions, however, are met with fairly long pauses (ll. 150, 152, 154 and 158) indicating P’s disagreement, or at least non-alignment with the role of advice recipient. In this respect it is reasonable to assume that the patient is resisting advice for its close-implicature rather than for its applicability (the doctor is only inviting her to keep working on what she is already doing!). Given P’s response, or rather absence of response, PR drops the subject and re-engages in history-taking proper (l. 159). In excerpts 1c-1e, which are the continuation of 1a, we will see that the primary tries to resume his advice-giving activity, this time, however, with a different modality. First, he gives room to P’s elaborations and responds to them, especially to those reinforcing the trajectory of achievement projected earlier on in the interview, with positive assessments. Then he replies to P’s expansions with his own stories, in which already-expressed general concepts are variously rephrased and made relevant to single individuals. Before a second story is introduced, however, something unexpected happens, as shown in the second half of excerpt 1c.

Excerpt 1c

230 → P  uh the: concept that it's you know,  
231    (0.8)  
232 P  mostly in your mind it's all mental. erm (.) she was:, a lot  
233      of other people are having problems with certain positions  
234      that, require like hand stand or balance. 
235     PR  uh huh.  
236 P  and they see it as: er strength exercise but she was trying  
237       to teach us that it's more, ((miming two pans in a balance))
(1.2) a combination of flexibility and strength.
not all strength.
PR [sure.]
P [ but ] some.
PR yeah!
→ P but if you alter your perception of what it is you're
tyling to do then it'll be easier to do. (. ) a:nd
PR ex [ actly.]
P [i'm not] having problems with any of the positions
except for:,
(0.5)
P tzt something called the tripod? not tripod, . h it's where
it's a hand balance you're basically,
(0.6)
P [ ba ] lancing on the hands with=
P =your knees on the back of your elbows?
PR [yeah,]
P [ ba ] lancing on the hands with=
P =your knees on the back of your elbows?
PR gotcha.
and we've only tried that once a long time ago. and i don't
know you know at this point if i can try again. but she
suggested not [ ;to hu ]
PR [do you?] do you do is it something that you
would like to do?
P yoga?
PR that pos- that particular,
P tzt position.
PR position.
P . h i think at this point because i was unable to do it
susses- successfully in my eyes the first time,
PR uh huh,
P that it's i'm i'm eager to try it again.
PR [great!]
P [ to ] see if i can get there.
(0.9)
P a:nd,
(1.1)
P mentally ((PR nods)) i know what i have to do and how i
(0.7)
P can do ;it and i see myself in the position? . h er even if
it's for a couple of seconds,

PR [ uh huh.]

P [(slb slb] slb) out there? but erm,

(1.0)

and i don't wanna hurt myself either. so i'm not trying any

of the,

PR yeah,

P very difficult positions

PR [uh huh.]

P [outside] of class.

(2.0)

PR good.

(0.6)

(UBNMC, INT7-11.14.03)

In line 232 P continues the story initiated in excerpt 1a by talking about people in her yoga class having problems with certain positions and thinking of those as strength exercises. In contrast, she mentions that her instructor is trying to teach them that yoga is not just strength but a combination of flexibility and strength (ll. 236-238), adding that it will be easier to do what you are trying to do if you change your perception of it (ll. 243-44), and thereby clarifying the concept already expressed in line 232 (“it’s all mental.”). The primary lets the patient speak without interrupting. He only provides a continuer in line 235 and three other items claiming understanding and agreement (“sure.” in line 240, “yeah!” in line 242 and “exactly.” in line 245). The patient proceeds by mentioning her difficulty with a particular position. She explains what it is called (the tripod) and what it involves (ll. 249-54). Once again the clinician pays attention to what is being said (he is also looking straight at the patient) and claims understanding (“yeah,” in l. 253 and “gotcha.” in l. 255).

At this point, however, an abrupt change in trajectory occurs: the patient says she does not know whether she will be able to try the tripod position again, and adds that her instructor has suggested she does not do so (note the emphasis on “not” in line 258). This seems to contradict the idea of accomplishment formulated in lines 243-44 (and already mentioned in ll. 232 and in excerpt 1b, l. 140), to which both partners in conversation have so far oriented, and to project a trajectory of ‘failure’ as opposed to the ‘success’ trajectory pursued by the primary. In order to redirect the conversation towards the key notion of accomplishment, PR elicits further considerations from P, by enquiring if the
patient really wants to achieve that position (ll. 259-60). The patient, who asks for clarification (l. 261) and collaboratively completes PR’s question (l. 262), explains that she is “eager” to try again (l. 268) precisely because she has failed the first time (note the phrase “in my eyes” in line 266, which refers back to the “impression of myself” of excerpt 1b, l. 115). The primary is satisfied with P’s response, which he approves by formulating an assessment (“great!” in l. 269) at the first transition-relevance place and in partial overlap with P’s subsequent turn. This assessment seems to signal PR’s satisfaction with P’s being ‘back on the right track’. In other words, it highlights P’s return to the idea of self-accomplishment and fulfilment, which perfectly accommodate the contents of PR’s advice in excerpt 1b.

In lines 274-79 the patient applies the general idea of a powerful mind working towards the achievement of goals to her own experience: she says that what she has to do is clear in her mind, as she can actually see herself in the tripod position. PR nods when the word “mentally” is reiterated (l. 274) and encourages P to go on in line 276. However, the patient insists that she does not intend to try difficult positions outside of class because she is afraid of hurting herself. A two-second pause and a delayed assessment follow (ll. 287 and 288 respectively), which signal that a disagreement is “in the works” (Sacks, 1987: 65). Another pause follows (l. 289), after which PR resumes talking:

**Excerpt 1d**

290  →  PR  erm you know life life is very,
291       (0.5)
292  PR  life forcing goals. and people who really accomplish
293       anything (.) they constantly have goals and if you read any
294  motivational book or er any er self er (.) personal
295  coaching book or any personal coach will tell you that, (.)
296  w- we need we function on goals. so if it's something that
297  you know again that you wanna accomplish,
298       (1.3)
299  PR  coz coz life is also about achieving things.
300       (0.8)
301  PR  and for whatever we achieve this is is important to us. or
302  whatever i achieve is very important to [ me. ]
303  P  [yeah.]
304  PR  whatever you achieve is very important to you is very
individualized very subjective. so,

PR c- certainly if

PR if something as

PR as important or mo- or as minor to other people but

important to you as making doing that

position in yoga,

PR and if that's truly important to you that's you should have

that as one of your goal.

(UBNMC, INT7-11.14.03)

In line 290 the primary corrects the trajectory projected by P’s turn for the second time (see ll. 259-60 in 1c). This time he does so by resuming the idea that “we function on goals” (l. 296), thus further elaborating the point formulated in the preceding few lines. He makes his statement generally valid by referring to “people”, “we” and “life”, while specifying that goals are very subjective (ll. 301-5). At the end of line 305 “so,” is presumably employed to request some kind of comment from the patient (cf. Jefferson, 1978: 231), but the request is met with silence (l. 306). The clinician responds to P’s pause by adjusting his claim once again: he turns what he has presented as a generally true statement into something relevant to the patient, by adapting it to her own specific situation. In lines 307-316 he states that if something is really important to her, like that position in yoga, she should consider that as one of her goals. Hence, by mentioning the yoga position once more, the primary has incorporated a component of P’s story and used it to formulate a ‘customised’ moral. This reference back to the story initiated by P in line 230 somehow makes up for the non-adjacency of PR’s second story, which is only introduced in excerpt 1e.

Excerpt 1e

i i i'll tell you long ago i had you know i had never (slb slb slb) and decided i wanted to run a marathon.

that meant nothing to other people.
PR for me it meant the world.
P "right".
(0.8)
PR and i kept running running running running and i (slb slb slb slb slb slb).
(0.6)
PR and this summer i i (thought get out of here i won i won a cool marathon) the point in being is that things like that
(1.0)
PR fill your spirit so much, this is a spiritual exercise.
P uh,
(0.6)
PR and physical obviously but mostly spiritual. coz you're like i did it.
(0.5)
PR is that feeling like i did it you know?= P =uh huh,
PR nothing er er is it's a powerful feeling.
(0.3)
PR and you don't get that feeling every day.
(1.0)
PR you know? you don't get that feeling every day you only get those feelings like every now and then.
P right.
PR you know that feeling of accomplishment i had a friend who just ran the new york city marathon. she did it in four hours and about twenty minutes.
(1.0)
PR she she was high. [she]
P [uh,]
PR was she was high.
P "exactly."
from the willingness (or even eagerness) to attain a given objective to the feeling that one has once that objective has been achieved. PR’s story, including its moral, is met with minimal acknowledgement tokens by the patient (ll. 324, 333, 339, and 346). The clinician insists on the feeling of accomplishment that you get as a result of a spiritual exercise. In particular, he highlights the exceptional nature of such a feeling, which he has just mentioned in lines 338-45, by recounting another story. This is very similar to the immediately preceding story, in that it is based on the same maxim and is also about a marathon, although it has a different protagonist (a friend of PR’s). In evaluating the feeling of accomplishment that his friend had after running the New York City marathon, the primary employs the expression “she was high.” (ll. 351-53; note the repetition), which is semantically linked to the patient’s playful reference to drugs in line 203 of excerpt 1a. In line 354 P produces a first weak signal of agreement (she whispers “exactly.”).

In excerpt 1f, as in 1c above, P’s resistance to PR’s projected trajectory emerges once again. This time, however, P explicitly acknowledges the reason for such a resistance (“my mental block” in line 375). In clearly stating the problem, P eventually moves towards the final alignment as advice-recipient, which is achieved in excerpts 1f and 1g.

Excerpt 1f

355 PR because she did something that really not everybody in the
356 world could do or everybody could do but er they don't.
357 (1.4)
358 PR so you know,
359 (0.3)
360 PR if that’s one of the things that you personally wanna do,
361 (0.4)
362 PR and you can't,
363 (0.4)
364 PR and along with with with your weight loss program, probably
365 when you start with losing just a few pounds, you're
366 [go ]nna=
367 P [uh,]
368 PR =be able to do that
369 P =uh,
370 PR position. coz,
371 P uh huh.
you know, [pro-] [e ]xactly.

PR right?

→ P well that's the thing! she said that my mental block of course was there's no way i'm getting this,

P hhh .hhh myself into that position,

PR right.

P w- with as heavy as i am.

PR right.

P erm

(0.4)

P but,

(0.4)

P she dismissed the, er she i didn't even vo- ver- vocalize it but she said,

(0.6)

P erm

(1.8)

P i don't know. (. ) maybe felt that i was thinking it, or

PR [uh huh,]

P [because] i may have seen str- pressure that i couldn't get into this (slb tion),

PR uh huh,

P erm

(0.5)

P just stated that it wasn't,

(1.6)

P you know, there is no reason you can't get into it regardless of your size regardless of your,

(0.7)

P stature height whatever. .hh you should be able to get into it if you want to. and you know just working on the lower belly, and the muscles are a little weak down there, i'm not doing any push up chair or sit ups right now. but erm,

(1.5)

(UBNMC, INT7-11.14.03)
Moving from the second marathon story and the extraordinary feeling of accomplishment that his friend had (ll. 351-53), PR gradually returns to what the patient wants to do and how she can achieve it (note P's claim in excerpt 1c, line 274), namely the yoga position and weight loss (ll. 364-70). These remarks seem to trigger a more assertive reaction on the part of the patient, who finally expresses her agreement explicitly in line 373 and initiates a third story (l. 375). Here the patient acknowledges that what is preventing her from reaching her goals is a mental block. To be more precise, she believes she will not be able to do the tripod position as long as she is so heavy (see ll. 376-80). In what follows (ll. 398-405) she explains that it is her yoga instructor who has pointed this out to her, and has tried to convince her that she can do it regardless of her weight if she wants to, by just exercising a little to reinforce her muscles. In recounting these details P holds the floor for a long time: her turns occupy over thirty lines and are only interspersed with PR's continuers (ll. 379, 381, 392, 395). Thereafter the following occurs:

Excerpt 1g

408 P it was encouraging to hear her say that and,
409 PR good.
410 (0.7)
411 P put me back in my mind to make you know to know that,
412 (1.4)
413 → P i can achieve anything that i put my mind to.
414 PR absolutely! absolutely and th- er you get that feeling that
415 i was just talking about. a feeling of i can.
416 P deter[ mi na tion?]
417 PR [the feeling ] of i can.
418 P uh,
419 (0.8)
420 PR that erm a hot feeling like (slb slb slb). and a hot feeling!
421 P uh huh.
422 PR like i can that feeling is an amazing feeling,
423 (1.5)
424 PR and you know er er and you're gonna definitely feel that
425 when you get to your erm the point where you wanna be as
426 far as er your body composition.
427 (1.0)
In line 408 P says that she has found the words of her yoga instructor encouraging. The primary’s contiguous “good.” is uttered in appreciation of what has just been said and is followed by the patient’s explanation of how the above-mentioned words have triggered a change in her way of perceiving what she can do and how. The significance of the whole series of stories clearly emerges in line 413 with P’s self-assured conclusion (“i can achieve anything that i put my mind to.”)\(^5\). This signals P’s uptake of PR’s previous suggestions and constitutes a final agreement (note the immediately following matching show of agreement on the part of the primary in line 414-15). At this point PR ‘wraps up’ the series of stories by referring back to his own description of the powerful “feeling of I can” (ll. 414-22), which is the *leitmotiv* of the series of stories. Having reached agreement on the fact that P can achieve anything that she puts her mind to (see l. 413), PR can finally resume explicit advice-giving in lines 428-30, which echo the suggestions already made in excerpt 1b (ll. 146-57). P’s claim in line 413 – an instance of what Pomerantz (1986) calls ‘extreme case formulations” – seems to trigger an enthusiastic reaction on the part of PR, who uses strongly evaluative language. In particular the adjective “amazing” (ll. 422 and 428) works as an assessment reinforcing once again the whole idea of achieving one’s own goals through the power of the mind, and consequently substantiating PR’s advice regarding the need for P to stay focused on her goals (see excerpt 1b above)\(^6\).

4. Conclusion: Maximising agreement through conversational resources

The single-case analysis carried out in the present paper has shown that patients may fail to orient to doctor-initiated advice-giving when this occurs early in the interview. However, the potential contrasts resulting from this non-alignment can be smoothed over by engaging in a jointly authored process of

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\(^5\) Note also the emphasis given by the long pause preceding P’s words.

\(^6\) These observations are in line with the naturopathic medicine focus on patients’ self-responsibility, as illustrated in Murray and Pizzorno (1998: 42).
storytelling, whereby participants collaboratively make sense of “specific situations and their place in the general scheme of life” (Ochs and Capps, 2001: 2), gradually bringing the conversation onto a ground where agreement can be more easily found. Such a conclusion seems to be in line with the observations made by Fasulo and Zucchermaglio (2005) on the use of narratives in institutional, and more in general, work-related settings, where difficult decision-making processes or contrasting views are involved. In particular, the primary’s second stories in the excerpts just analysed, by “evoking concrete instantiations of possible worlds” (ibid.), help to envision a solution for the problematic course of action described by the patient, thus facilitating next moves (in this case premature advice-giving). Also, the primary’s use of assessments throughout the conversation contributes to the process of mutual ratification of participants’ roles (particularly advice-giver and advice-recipient) within the interaction.

Overall, the analysis conducted has contributed to explode one of the myths characterising a significant share of literature on doctor-patient interaction, namely doctors’ neutrality towards patients’ concerns. In particular, we have seen that naturopathic doctors do not necessarily refrain from using evaluative language, and we have found numerous displays of involvement and affiliation used to align as recipients of patients’ stories. Given the constraints characterising the medical interview (especially time constraints), it may be claimed that such displays hinder speedy and efficient data gathering, thus compromising effective communication. However the investigation conducted in section 3 provides some evidence that this is not always the case.

First, the use of evaluative language in the data examined should not be confused with so-called “emotional communication”, i.e. the “spontaneous, unintentional leakage or bursting out of emotion in speech” (Caffi and Janney, 1994: 328). Rather, it is an example of “emotive communication”, i.e. the “intentional, strategic signalling of affective information in speech and writing (...) in order to influence partners’ interpretations of situations and reach different goals” (ibid.). In excerpt 1a-g the doctor seems to be fully aware of the ‘dispreferred’ position of his initiatives, and of the resistance this may cause on the part of the patient, and therefore tries to ‘fix’ potential mismatches by taking remedial and/or pre-emptive actions aimed at seeking agreement while at the same time pursuing his own medical agenda. To be more precise, knowing that advice-giving is ‘closing implicative’ (cf. Jefferson and Lee, 1992) and therefore ‘out of order’ with respect to the history-taking stage of the interview, he engages in the co-construction of a long storytelling sequence with the patient to make advice more acceptable.
Second, our analysis of a storytelling sequence has shown that the “voice of medicine” and “the voice of the lifeworld” (cf. Mishler, 1984) may interpenetrate in naturopathic interviews. In particular, we have seen that doctors do not necessarily silence their patients, but may give them room to speak about their concerns and, in so doing, may themselves speak with the voice of the lifeworld, using conversational resources – specifically assessments and second stories – that make it possible to reach a high level of intimacy with patients. This intimacy may seem unusual in institutional encounters; however, as stated by Tannen (1990: 26), intimacy is “key in a world of connection where individuals negotiate complex networks of friendship, minimise differences, try to reach consensus, and avoid the appearance of superiority, which would highlight differences”.

Doctors’ and patients’ engagement in conversational activities like storytelling, by establishing a frame of understanding (cf. Kjaerbeck, 2005), arguably facilitates convergence within task-oriented activities like history-taking and advice-giving, which may generate miscommunication or conflict. In particular, the use of conversational resources like displays of involvement and affiliation in doctor-patient talk cannot be considered a waste of time for at least two reasons. On the one hand, it provides evidence of “agreement as to content” (Aston, 1988: 123ff.), i.e. convergence as to the cognitive and affective components of the interaction, and thus – arguably – its primary goals. On the other hand, it provides evidence of “agreement as to context” (ibid.), i.e. the mutual accessibility and acceptability of participants’ worlds as a current context, which entails an ongoing negotiation of participants’ roles and activities.

Ultimately, doctors’ and patients’ collaborative engagement in intersubjectively performed actions that are methodically shaped and reshaped over the course of the talk (cf. Zimmerman and Boden, 1991: 10) shows that, as Maynard (1991: 486) put it, doctor-patient talk “may have an institutional mooring, but it also has an interactional bedrock”.

22
References


Appendix: Transcription conventions

= latching
[ ] overlapping talk
( . ) time gap shorter than 0.2 seconds
(0.3) time gap in tenths of a second
di- truncated word
: sound lengthening
. falling intonation
, rise-fall in intonation
? rising intonation
! fall-rise in intonation
↓↑ marked falling or rising intonational shift
h/hh out-breath
.h/.hh in-breath
you emphasis
°° words spoken more quietly
tzt lipsmack
(slb slb) number of syllables in an unclear segment
((nodding)) non-verbal activity or transcriber’s comments
→ phenomenon of interest