

On predicating a diagnosis as an attribute of a person



Discourse Studies
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 SAGE Publications.
 (London, Thousand Oaks,
 CA and New Delhi)
 www.sagepublications.com
 Vol 6(1): 53–76.
 1461-4456
 (200402) 6:1;
 10.1177/1461445604039439

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ABSTRACT This article explores the relation between ‘citing the evidence’, or implicating a particular diagnosis, and ‘asserting the condition’, or overtly predicating the diagnosis as an attribute of a person. Clinicians regularly postpone or delay asserting the condition, which is interactionally more confrontational and presumptive. They regularly do the postponement by citing the evidence *prior to* asserting the condition, using the evidence as kind of predecessor account for predicating the diagnosis as an attribute of the person. Citing the evidence as leading to asserting the condition enhances the likelihood of recipients realizing some bad news or other kind of diagnostic upshot. This study has implications for the relation between interaction and authority in medical discourse.

KEY WORDS: *authority, bad news, conversation analysis, diagnosis, doctor–patient communication, interaction*

Upon finding a patient or person to have a clinical condition, a problem for clinicians in delivering the diagnosis is to establish the condition as an attribute of the person under consideration. My phrasing here is chosen carefully. I do not mean that, in some general sense, it is difficult for clinicians to deliver diagnostic news, although, in a general sense, this may be true.

What I mean more specifically is that, in a collection of clinical presentations of diagnosis, two major devices present themselves. One such device is what I call ‘citing the evidence’, and the other is ‘asserting the condition’ (Maynard, 1991a). Citing the evidence – reporting test results – is what clinicians do as a cautious way of declaring a diagnosis, whereas asserting the condition – predicating it as an attribute of a person – is interactionally more forthright and bolder.

Consequently, clinicians most regularly postpone or delay asserting the condition. As we shall see, the predominant way in which they do this is by citing the

evidence *prior to* asserting the condition, using the evidence as a resource, a predecessor account, for predicating the diagnosis as an attribute of the person.

The aim of this article is to examine these devices or practices of news delivery in relation to a phenomenon that Houtkoop-Steenstra (1987) explored in her early work, that of 'establishing agreement' by way of proposals and their acceptances. A key word here, and one that I shall use throughout, is *proposal*. When clinicians have identified a condition in a patient, they work to propose the diagnosis to the patient or possibly a family member and obtain some display of acceptance to this proposal. This is a prospect fraught with interactional tensions, as the use of practices such as citing the evidence and asserting a condition exhibits. For example, Peräkylä (1998, forthcoming) has given extensive consideration to related devices as deployed in internal medicine clinics, referring to them as 'explicating the evidence' and 'plain assertions', and finding that they play a significant role in the establishment of doctor–patient intersubjectivity and medical authority. A dilemma exists in diagnostic phases of the medical interview, Peräkylä argues, in that the authority of the physician must be reconciled with the patient's own knowledge of bodily conditions. To resolve this dilemma, physicians work to establish a shared, objective basis for diagnosis, and this work is apparent in an association between the local availability of evidence and the two strategies of explicating the evidence and using plain assertions.

When physicians are in the process of examining a patient, and the evidence for a diagnostic pronouncement is literally at hand, they are likely to use plain assertions. The 'inferential distance' between its grounding and the diagnosis *per se* is minimal. As that distance increases or, in other words, there is temporal separation of examination and diagnosis within the same interview, or when the evidence is opaque because of multiple examinations the doctor is performing on the patient's body, then physicians are more likely to display the grounds of the diagnosis by explicating the evidence. They may, as Peräkylä (forthcoming: 16) puts it, 'retrieve the examination of the patient as a context' for the diagnostic talk.¹ In these ways, physicians establish the mutual intelligibility of their diagnostic pronouncements, thereby to strike the balance between their authority in medical matters and patients' self-knowledge of bodily conditions.²

Although this picture captures patterns in my data, and is extremely important for understanding medicine as an institutional practice, there are aspects of the local interactional dynamics in need of further appreciation. In addition to issues of authority and professional accountability in clinic settings, that is, we need an understanding of the ordering of conversational practices related to matters that are not intrinsically connected to the institutional environment in which they are deployed. Rather, the ordering of discourse in institutional settings may be dealing with matters that are endogenous to the interaction order as it undergirds occasions of professional–client communication (Maynard, 1991b; Schegloff, 1988). My aim here is to show how the devices of citing evidence and asserting conditions have import beyond their associations with the relative presence of diagnostic findings. Simply put, they are systematically

related to one another and to interactional problems of mutual understanding that are more common than their occurrence in the medical interview as a form of institutional discourse. After describing and analyzing my data, I will return to this issue of interaction and institution.

Data and settings

Having briefly reviewed Peräkylä's findings, it needs to be noted that he investigates diagnostic presentations where medical conditions are both confirmed and disconfirmed. The 'explicating evidence' and 'plain assertion' devices can refer to evidence and assertions for either the presence or absence of disease.³ For this article, my data all involve diagnostic news that confirms the presence of medical conditions.⁴ Hence, I continue to use the phrases 'asserting the condition' and 'citing the evidence', and I will be discussing three environments of diagnostic news delivery. Predominantly, for sake of simplicity, I concentrate on the informing interview in two Developmental Disabilities (DD) clinics when clinicians disclose to parents that a child has mental retardation, autism, learning disability, attention deficit disorder, or some other condition. The data are both audio and video. Another environment of diagnostic news delivery is an anonymous HIV-antibody testing clinic. Although examining just one case in this article, I have audio-recorded a number of sessions in which a counselor (CO) gives the client (CL) his test results. Finally, I analyze one video-recorded interview from an internal medicine clinic to illustrate the generic robustness of a particular pattern in the overall corpus, and to return to issues raised in Peräkylä's work with internal medicine data.

My data in the DD and HIV clinics differ from Peräkylä's in an important way. Testing in HIV clinics (until recently) and in DD clinics is at both temporal and spatial distance from the delivery of diagnosis. In developmental disabilities (DD) clinics, a variety of specialists, including speech pathologists, physical and occupational therapists, psychologists, psychiatrists, neurologists, pediatricians, and others, separately, and for an hour or so each, examine children during evaluations that cumulatively last for a day or two. When the testing is done, the clinicians meet to decide upon a diagnosis, and then, either as a group or with a few representatives, reassemble with the parents. A case manager delivers the diagnostic news. In the HIV clinic where I did field research, lay counselors meet with clients to discuss life-style and other matters surrounding risk for HIV exposure. At the end of the counseling session, a nurse draws the client's blood to send to a state-sponsored laboratory for testing. After two weeks, the results are returned to the clinic, and clients return to hear the news. Also, in the internal medicine clinic, an endoscopy was performed on the patient several days prior to the delivery of diagnosis. Thus, in all cases for this article, the diagnostic process involves separation between testing patients or clients and the subsequent news delivery, which means that this feature is constant rather than variable across my collection. This constancy – where the examination or testing is remote from

the news delivery – permits a concentrated focus on the way that clinicians employ, and recipients respond to, the two devices for diagnostic presentations.

Two devices for delivering diagnostic news

I will analyze the two devices of citing the evidence and asserting the condition in their sequential contexts and in relation to one another. Before the fuller analysis, a few characteristics of each need mentioning.

ASSERTING THE CONDITION AS A PREDICATE

When clinicians present a diagnosis by asserting the condition, the condition is then predicated as an attribute of the primary figure.⁵ Such assertions have the format:

person + has/is + a named condition.

In the DD clinic, examples of this format are when a pediatrician says to the parents of a five-year-old boy, 'he is slow, he is retarded' (example (2) below; also Maynard, 2003: 79–87), or another clinician states, 'Kirby has a problem with language' (NY22;⁶ Maynard, 1991c: 183–4). And there are variations on this format. Clinicians may use other copulae besides the *be* form, and may hedge or mitigate before pronouncing the diagnostic terminology, as in 'Dan's main problem you know does involve you know language' (NY8; Maynard, 1992: 337–9), or '[James] has what we would describe as learning disabilities' (NY20).⁷ These variations in the assertive format reflect that the device is embedded in discrete sequential environments, including what has gone before in terms of displays of perspective on the part of recipients (Maynard, 1992), the presence or absence of citations of evidence (discussed below), the responsiveness of recipients as the delivery is in its course, and other phenomena.

CITING THE EVIDENCE AS REFERRING TO TESTS OR RESULTS

Citing the evidence, in the DD clinics, also may be done in a variety of ways. Largely, clinicians refer to 'tests', 'evaluations', or 'examinations', and do so by announcing what assorted measures 'showed' (NY9) or 'revealed' (NY18). References to measurements are part of the turns that report what the findings are, as clinicians express what they 'can see' (NY10; Maynard, 1989: 57), or 'found' (NY17; Maynard, 1989: 59), or 'determined' (NY23). Sometimes, such references are in pre-announcements rather than the announcing turns as such. At or near the opening of an informing interview, for example, a clinician may say, 'So now we are trying to uh you know tell you what our findings are' (NY12) before obtaining a go-ahead signal from recipients and proceeding to tell them the findings. In the HIV clinic, counselors refer to 'results' and do so in pre-announcements at the beginning of an interview: 'I'll give you your results?' (B01). Or, more frequently, reference to results is in an announcing turn: 'Okay, your results came back positive' (B52).

Asserting the condition baldly

If we consider diagnostic news as a kind of clinical assessment, then delivering the news is like producing assessments in ordinary conversation. The latter activity *presumes* the data or knowledge or expertise on which the clinical assessment is based (Pomerantz, 1984a: 57). Similarly, when clinicians tell recipients of an assessment without citing the evidence, it is also presumptive and, moreover, a kind of bald assertion.

For instance, in one interview at the DD clinic, the pediatrician, Dr Norris,⁸ starts discussion by saying that the clinic was not able to come up with an answer as to why Mrs Lester's son Ricky 'has the problem he has'. Clinicians and parents display agreement that he was 'slow', and as Dr Norris elicits the mother's own observations, he works to state, in a way consistent with those observations, that, although her son is age six, the clinic's 'impression' is that he 'resembles' a 'two and a half' year old. Furthermore, the 'point of this', Dr Norris suggests, is to know what the child's capabilities are, what he can and cannot do, because 'if what you are asking him to do is too hard for him, he won't do it and that may look like he's disobedient when actually he didn't understand it' (57.081–57.094). Thus, one interpretation of Dr Norris' line of talk is that she is proposing to scale back the parents' expectations for their son, as she goes on to say that knowledge of Ricky's capabilities would make things 'easier all around' (57.115). Immediately thereafter, she initiates the delivery of the clinic's official assessment or diagnosis (arrow):

(1) 57.115

- 1 Dr N: → Bu:t uhhm (3.1) ahhh (0.3) Ricky is a retarded chi:::l:d.
 2 (1.0)
 3 Mrs L: (°yeah?°)
 4 Dr N: A::n:d (0.2) it's no:t mi:::l:d- it's mo:::derate retardation
 5 (0.2)
 6 Dr N: As far as we can estimate .hhhhh We can':t give him exact
 7 psychological tests:: (.) It was tri:::ed.hhh but he: (.)
 8 just wasn't cooperating enough to do i:t. (0.2) Hhhe::: uhhhh
 9 (0.4) was too afrai:::d or to scar:::ed or (0.1) it was
 10 just (0.5) too frightening a situation (.) So we can- (0.1)
 11 we can':t really feel we've got a completely correct (0.2)
 12 psychological: testing on him.
 13 (1.9)
 14 Dr N: But- (.) there's (0.1) significant (0.1) retardation (0.1)
 15 what we would call moderately retarded.hhhh Now (.) children
 16 with moderate retardation (0.4) are sen:t to school. . .

The device for delivering the news is asserting the condition, and thereby predicating retardation as an attribute of Ricky (line 1). After a silence (line 2) Mrs Lester produces a questioning token (line 3), and Dr Norris moves to specify the level of retardation (*moderate* being one level below the least form of retardation, which is *mild*). Subsequently, she characterizes the basis for this assertion as an

estimate because the clinicians were unable to administer 'exact' testing (lines 6–8); Ricky was uncooperative and somehow afraid (lines 7–10). Following this report, Dr Norris reformulates the lack of 'correct' testing (lines 11–12). Here is a 'transition relevance place' (Sacks et al., 1974: 705), where Mrs Lester could take a turn to talk, but a substantial silence develops (line 13) before Dr Norris elects to continue. Given the lack of evidence, it seems at least possible that she would hedge in the diagnosis but instead she reformulates the condition as 'significant' (line 14) and repeats the official diagnosis as 'moderately retarded' (line 15). Once more, some uptake from Mrs Lester may be due, and lacking this uptake, Dr Norris breathes in and advances to discuss schooling options (lines 15–16 and beyond).

In this case, clinicians were unable to test the child and have no hard evidence to cite on behalf of the diagnosis. This may be one reason that, preceding the above extract, there is discussion of clinical and familial observations regarding Ricky, as if these can stand proxy for the testing, in addition to being the basis for Dr Norris' cautions about appropriate expectations for the boy. Still, Dr Norris' presumptiveness is clearly displayed after she asserts the condition, when she topicalizes their lack of test results and goes on to reaffirm the diagnosis. And if Dr Norris' assertive delivery is presumptive, in the context of discussions about expectations for Ricky, it is also confrontational. She presents the diagnosis on the basis of observations but without hard evidence and in a way that can reinforce the immediately previous suggestions that Ricky is not capable of performing at the level his chronological age otherwise would suggest as appropriate.

Mrs Lester, however, mostly remains silent as the diagnosis is delivered, and we do not have verbal indications as to how she experiences the assertive format. In another interview in which a pediatrician employs the assertive device, however, a mother produces verbal and affective displays that are strongly oppositional. The DD clinic diagnosed seven-year-old Donald Riccio as 'mildly' mentally retarded. Both parents are at the interview, and Dr Davidson begins by claiming a recognition of their plight as parents – complimenting them on the job they have done (line 1 below) and repeating (from previous talk not on the transcript) how 'hard' they have had it (line 2). Then at line 4, after proposing that something 'is the matter' (lines 2–3), Dr Davidson asserts the condition (arrowed), at first in a vernacular way ('he is slow') and then with the official term ('he is retarded'):

(2) DD #11

- | | | |
|---|--------|---|
| 1 | Dr D: | And I admire <u>both</u> of you really and (0.8) an' (2.2) as |
| 2 | | <u>hard</u> as it is (0.4) seeing that there <u>is</u> something that |
| 3 | | <u>is</u> the matter with Donald, he's <u>not</u> like other kids (0.2) |
| 4 | → | he <u>is</u> slow, he is retarded. |
| 5 | | (0.2) |
| 6 | Mrs R: | HE IS <u>NOT</u> RETAR[DED!] |
| 7 | Mr R: | [Ellen.] |
| 8 | Mrs R: | HE IS <u>NOT</u> RETARDED!= |

- 9 Mr R: =Ellen.
 10 (0.3)
 11 Mr R: Uh plea:s::e
 12 Mrs R: NO::!
 13 Mr R: May- look- (0.6) it's their way of:: I'oh'know.
 14 Mrs R: hhhhh HE'S NOT RETAR:(ghh)DED! ((sobbing))
 15 (2.5)
 16 Dr D: He can learn and he is lear[ning]
 17 Mrs R: [hhhh]
 18 Mr R: Yes [he is learning] [I-]
 19 Dr D: [and he's making] good prog[ress.]
 20 Mrs R: [.hhhhhhhhhhhhhhhh]

As I have analyzed the segment in some detail previously,⁹ here I will just point to Mrs Riccio's vigorous displays of disagreement (at lines 6, 8, 12, and 14). Besides being vigorous, they are simple negations of the predicate that Dr Davidson asserted, and without evidence having been cited, there may be no other way to dispute the news. Mrs Riccio's husband, attempting to quiet her, appears to align with the clinician (lines 11, 13, 18). At line 15, all of the parties stop talking, and then (lines 16, 19) Dr Davidson engages a kind of *good-news exit* (Maynard, 2003: Chapter 6) from what is characteristically the bad news of mental retardation, suggesting that Donald 'can learn' and 'is learning'. Meanwhile, at lines 17 and 20, Mrs Riccio is audibly sighing in overlap with her husband's and the pediatrician's talk. Thus, without citing the evidence, predicating a condition as an attribute of a person may be designed as a bold confrontation and, through strong displays of opposition, handled as such by the news recipient.

Citing the evidence as a predecessor account to asserting the condition

Bald assertions of conditions, very rare in my data, appear as both presumptive and confrontational. Much more regular is the practice of asserting the condition in combination with citing the evidence as a *predecessor account*. Before announcing an official diagnostic term in a predicative fashion, clinicians display the testing knowledge on which it is based. In another case involving mental retardation, Dr Brady opens the informing interview by asking Mrs Mill what she thinks her son John's 'problem' is. Among other things, she replies that he 'won't do nothing' and that he won't talk, or 'maybe he can't'. Then, Dr Brady proceeds to deliver the diagnosis (arrows below), first agreeing with the latter suggestion of Mrs Mill that John 'ca:n't yet' talk (line 2):

(3) 33.064

- 1 Dr B: Well (0.5) No we- we: would (0.4) we feel that (0.2) the
 2 problem is that he ca:n't (.) yet.
 3 (0.9)
 4 Dr B: → And that he- (0.2) all our exams show that he is (.) quite

- 6 Dr I: =very much at home, (.) a lo[t at ho]me
 7 Mrs S: [mm uh::]
 8 (0.4)
 9 Dr I: 1→ Okay. (0.6) um:: (1.2) when we tested hi::m:: we found that
 10 there was a problem with the way his brain was functioning.
 11 (0.8)
 12 Dr I: Ok[ay]
 13 Mrs S: [Mm] hmm
 14 Dr I: Tha::t there were two::? (0.2) major things that were going
 15 2a→ on. (0.4) One::? was tha::t he was somewhat slow for his
 16 age.
 17 Mrs S: Right ye[ah]
 18 Dr I: 2b→ [Li]tle bit. No:t very much (0.2).hh and the other
 19 wa:s tha::t (0.4) he:: had a problem with the way he saw the
 20 wor::ld, I mean that's the best way I can put it.
 21 (0.4)
 22 Dr I: He:: had a problem wi::th uh::m (0.8) he duh- he doesn't
 23 exactly see: things::: the way we do.
 24 (1.6)
 25 Dr I: A:n::d (0.2) this accounts for so::me (.) of the behavior
 26 that's reported, I dunno he likes to twirl a lot . . .

Notice that, after the doctor proposes the reason-for-referral, there is a very delayed response (at line 5) from the mother. That is, although she produces an agreement token 'yeah', its onset is after a silence (line 3), after Dr Ivan begins a continuation of his turn (line 4), and after a verbal marker of hesitation, 'um:::' Apparently dealing with this delayed response, Dr Ivan's continuation reformulates the reason for referral. Where the first proposal only mentioned a referral from school because of Samuel's 'behavior', the reformulation both exacerbates the description – suggesting a 'problem' with his behavior – and adds a contrasting component to the effect that the mother 'didn't see very much' of this problem 'at home'. On the part of Mrs Smith, there is again a delayed response (at line 7); meanwhile, Dr Ivan recompletes his turn with a component that re-phrases how much she had seen the problematic behavior at home (not 'very much' is changed to not 'a lot'). Mrs Smith, in overlap at line 7, equivocally aligns with the doctor's proposal.

As a revised reason-for-referral, the doctor's second turn (lines 4, 6) in this excerpt exhibits a possible source of trouble in the first formulation (Davidson, 1984: 107; Pomerantz, 1984b), that it represented the school's point of view but not what the mother saw at home. In other words, relative to the school's perspective, Dr Ivan portrays her view as doubtful about her child's problem and thereby shows a basis for her resistance to any further pursuit of the proposal that the child has behavior problems. Such an analysis of the mother's point of view is apparent in the type of delivery the clinician then engages, which is citing the evidence for a brain problem and, moreover, emphasizing the testing that produced the evidence. At line 9, after turn-initial hesitations, he says 'when we tested hi::m:: . . .'. Emphasis on the verb here is contrastive, audibly differentiating

the clinic's evidence from the 'seeing' or casual observation the mother could do at home. There is another emphasis component to the utterance, where the doctor says there 'was a problem with the way his brain was functioning' (line 10). That emphasis also can mark the clinic's findings as different from the mother's point of view, and tie to the original formulation of there being a problem, proposing to confirm that formulation.

While Mrs Smith does not immediately align to the evidence citation (silence, line 11), she does, after an 'okay' token (line 12) from Dr Ivan that may solicit a response, produce a continuer (line 13). Then, Dr Ivan goes on to assert the two conditions, first predicating the 'somewhat slow for his age' assessment (lines 15–16). Mrs Smith immediately receipts this with tokens of agreement (line 17). However, after further qualifying this condition, and asserting 'the other' as a 'problem with the way he saw the wor::ld', as well as claiming difficulty with how to 'put it' (lines 19–20), there is another silence. Dr Ivan goes on to reformulate this diagnosis (lines 22–3) as 'a problem with . . . seeing things . . . the way we do'. This reformulation is followed by an even longer silence (line 24).

So far in this case, and in a sequential context where the clinician himself exhibits his recipient's perspective as in disagreement with others' proposals of problems, citing clinical evidence tentatively contradicts her view by corroborating the existence of problems. It also thereby implicates a more auspicious environment for, and less presumption in, asserting the condition. In that sense, citing the evidence is certainly a resource for asserting the condition, but notice some possible circularity. Generically put, once a diagnosis is predicated as an attribute of a person, and in the face of (further) signs of disaffiliation from the news recipient, the diagnosis itself becomes a resource for disputing the recipient's contrary perspective. In excerpt (4), the diagnosis ('this', line 25) 'accounts for' behavioral problems that citing the evidence had also worked to establish. This implies that, although the ordered pair of citing the evidence and asserting the condition means a less presumptuous way to predicate a diagnosis as an attribute of a person, it may not solve the disparity of perspective between clinician and recipient. Then the diagnosis can be proposed as a retrospective validation of the problem proposal that helped to lead up to the assertion. Overall, by suggesting the diagnosis as an account after proposing problems, citing evidence that both confirms the problems and anticipates a diagnostic predicate, and finally asserting the condition, where each of these moves meets recipient resistance, the clinician offers to correct the recipient's stance rather than confront the recipient and pursue conflict in a way that outright assertion of the condition can do.

Alluding to a diagnostic predicate through citing the evidence

Clinicians cite the evidence as a resource for asserting a condition when they use the evidence as a predecessor account. Similarly, clinicians use citations of evidence to allude to a diagnostic predicate; they imply a condition as an attribute of a person but do not state the predicate outright. Recipients of the diagnostic

news can infer the condition in a predicative fashion, as is evident in another case involving mental retardation. Dr Yost, a psychologist, begins the informing interview by telling Mrs Rivers this about her five-year-old son, Ronnie:

(5) 36.021

- 1 Dr Y: From the: test results (0.3) he seems to function (0.6)
 2 comfortably (0.2) you know and (achieve) some kind of you
 3 know happy and responsive
 4 (0.2)
 5 Mrs R: Ye[:s]
 6 Dr Y: [.h]hh ON THE LEVEL of about you know three (0.1) three and
 7 a half year old child.
 8 Mrs R: Mm hmm.

Beyond this excerpt, Dr Yost reports that Ronnie tests 'very evenly on this level'. She also describes problems with articulation, Ronnie's own apprehension about his speech, and the need for continued speech therapy.

So far, then, Dr Yost has reported test results and not asserted any condition as an attribute of Ronnie. Instead, after the discussion of language problems, the psychologist produces an educational recommendation:

(6) 36.071

- 1 Dr Y: For the school placement,
 2 Mrs R: Mm hmm
 3 (0.8)
 4 Dr Y: I feel very strongly, that you know, because he (0.4) tests
 5 some kind you know, functions between mildly retarded and
 6 borderline level [.hhhhh] he needs special class placement.
 7 Mrs R: [Mm hmm]
 8 Dr Y: (Yeah) the (.) class for (0.2) .hh educable mentally retardet
 9 (0.2) will be the best (.) for his (0.8) you know?
 10 functioning and emotional, he's still not ready you know
 11 enough [to be more-]
 12 Mrs R: → [Are y- are you tr]yin' ta tell me that you feel he
 13 → is: s:lightly mentally re[tard]ed?
 14 Dr Y: [Yes.]
 15 Mrs R: Yes.
 16 (0.2)
 17 Mrs R: In which way?
 18 (0.6)
 19 Dr Y: In all ways, you kno:::w . . .

In making her recommendation, Dr Yost again refers to how Ronnie tests (lines 4–6), this time formulating his performance or functioning as between 'mildly retarded and borderline level'. Just after this utterance, Dr Yost takes an inbreath (line 6) as Mrs Rivers produces a continuer (lines 7), and then Dr Yost advises 'special class placement'. She is using the formulation of test performance as a justification for recommending this placement, which turns out to be a class for the

'educable mentally retardet' (line 8). Accordingly, the clinician is offering to move to a next phase of the informing interview; i.e. in Heath's (1992) terms, is moving from a consideration of diagnosis to a discussion of how to manage the child's retarded condition. Thus, while the psychologist has presented all the evidence for Ronnie's condition, and alluded to this condition by formulating it in terms of test performance, she has not predicated the condition as his attribute as such.

However, as Dr Yost projects further talk that would justify the placement (lines 9–11), Mrs Rivers interrupts (line 12) to *ask* if the clinician is asserting the condition for her child. In her questioning, she asserts the condition by way of a proposal (arrows), and Dr Yost, in line 14, confirms this proposal.¹¹ The mother's emphasis on 'is:' provides a contrast with the clinician's reference to how Ronnie 'tests' (line 4) or 'functions' (line 5). Furthermore, what transpires here is related to a device elsewhere described for giving bad news (Maynard, 1992; Schegloff, 1988; Terasaki, 1976). The bringer, rather than telling it, rather purposely clues a recipient ('Y'know your Grandpa Bill's brother Dan?') so that the recipient guesses the news – asserts the condition ('he died?') – and the bringer can then corroborate ('Yeah'). Differently in excerpts (5) and (6), it appears that the clinician, by citing and formulating evidence in particular ways, and following this talk with an educational recommendation, is working to *avoid* a predicate assertion in relation to Ronnie while presuming it in relation to educational recommendations. She gets called up short by the questioning tactic of her recipient, and then confirms the condition as an attribute of the child.¹²

Labeling the evidence

Excerpt (6) suggests that there is a particular practice for talking allusively in the environment of diagnostic news delivery. A clinician inexplicitly can convey and a recipient can understand a condition or diagnosis to have been predicated as an attribute of the person. However, the diagnostic term is inserted by way of a different social action than asserting the condition *per se*.

Above, that action was to cite the evidence by characterizing a child's test *performance* in terms of retardation. Closely related to this practice is citing evidence and then labeling the evidence (rather than the performance or functioning) with a diagnostic term. For instance, we have discussed a 'syllogistic' delivery of diagnostic news (Gill and Maynard, 1995; Maynard, 2003: 213–14), when a psychologist reports the findings from a child's clinical examinations and abstractly defines what they mean diagnostically. In excerpt (7), Dr Meyer is a psychologist who is delivering the news to Mr and Mrs Davis, the parents of five-year-old Ken, who has been tested extensively in the DD clinic. In previous talk, Dr Meyer, on the basis of his own and other clinical examinations, has cited the evidence by reporting test results to the effect that Ken's delays are significant, pervasive, untreatable, and permanent. Mr and Mrs Davis have acknowledged these assessments. Now, at lines 1–2, 4, and 7–11, he re-references the clinical findings. In other words, he is '*reciting the evidence*':

(7) L (45:17)

- 1 Dr M: When:- when you put a:ll these things together. When there
 2 are [dela:y]s,=
 3 Mrs D: [°M hm°]
 4 Dr M: =When they're significant, and it looks like there's no:
 5 (0.8)
 6 (Mrs D): °m°
 7 Dr M: clear treatable cau:se. .hhh uh- ta fix: (.) the problem up.
 8 .hh uh:: (.) a:n when it looks like this has been going on
 9 for a long period of ti:me, .hh (0.5) an:::d (0.5)
 10 projecting ahead you're:: not optimistic that the kid's going
 11 to catch up, [.hh uh]=
 12 Mrs D: [°M hm°]=
 13 Dr M: =that's what we call mental retardation.
 14 (1.5)
 15 Mrs D: → And this is what it is.
 16 (0.5)
 17 Dr M: °M hm.°=
 18 Mrs D: =°Okay.°=
 19 Dr M: =°Yeah.° Almost certainly.

In reciting the evidence, Dr Meyer employs what Lerner (1991) calls a compound turn constructional unit, consisting of the initial component, the 'When . . .' statement from lines 4 through 11, plus a second component wherein he labels the evidence as 'mental retardation' (line 13). (After the first component, Mrs Davis, at line 12 and in overlap with Dr Meyer's inbreath and 'uh' token (line 11), produces a continuer.) Following a silence (line 14), Mrs Davis responds with an utterance (arrow, line 15) using indexical or deictic expressions ('this', 'what', 'it'), which can be a way of preserving rather than unpackaging the allusive reference (Lutfey and Maynard, 1998). And, comparable to a similar procedure in excerpt (6), her use of 'is' in the arrowed utterance provides a contrast with Dr Meyer's formulation about what they 'call' mental retardation (line 13). At lines 17 and 19, Dr Meyer confirms her allusive utterance. Thus, where Dr Meyer has alluded to Ken's condition by labeling his delays and problems as mental retardation, the mother as news recipient also speaks allusively through indexical expressions that refer without explicit labeling, although she also hearably transforms 'mental retardation' from a term fitted to the evidence to something applicable to her child. Neither party, then, except by way of Dr Meyer's generic formulation of 'the kid' (line 10)¹³ references Ken in particular. Nevertheless, mental retardation can be understood as having been predicated as his condition.

Practices for allusive talk about diagnosis, instead of occasioning an immediate predication, may stand proxy for asserting the condition, and, as excerpt (7) shows, subsequent talk can treat predication of the condition as 'virtually having been conveyed' (Schegloff, 1988: 444, fn.3). For instance, slightly later in the discussions about Ken (not in the transcript above), and in answering a question

from Mr Davis about 'what age' Ken would grow to, Dr Meyer says, 'Right now *his level of mental retardation* is what we call mild' (my italics), thus attaching the condition to Ken as if that explicitly had been done already.

Occasioning a predicate assertion after citing the evidence and inquiring about expectations

Citing the evidence is a resource for asserting the condition in many different ways. Examples so far have been from the DD clinic, the party whose condition is conveyed is a child, and the clinician conveys the news to the parent. Now I wish to shift to a different venue and consider a case where a counselor tells a client at an HIV testing clinic that he has tested positive for the virus.

Thus, the clinician is delivering the tidings to the party who has the condition. In this excerpt, the counselor (CO) initially cites the evidence, and then asks a series of questions regarding the client's (CL) expectations concerning the news. This helps prepare an auspicious environment for predicating the condition as an attribute of the client. Citing the evidence includes results from two tests. First (lines 1–2), the counselor refers to the ELISA,¹⁴ which is a very sensitive but non-specific test for HIV antibodies. Then, he reports that the 'western blot' (a more specific test) confirmed the presence of antibodies (lines 2–4).

(8) B68:05

- 1 CO: Okay..hhh they did the resa- the te::st..h and on the eli::sa
 2 (0.3) it did come back reactive or positive, oka::y?.hhhh They
 3 then did the western blot (0.3) and that also came back reactive,
 4 okay so that's the confirmatory. .hhhhh I didn't do your pretest,
 5 were you expecting this?
 6 (1.2)
 7 CL: Yea::h. hhh
 8 CO: What made you expect it?
 9 (0.2)
 10 CL: Lumps on the neck.
 11 CO: Okay. How long have they been there?
 12 (1.0)
 13 CL: Couple months
 14 CO: Where (0.1) in the neck, in the back?
 15 CL: Yea::h.
 16 CO: () (I feel?)
 17 (5.4) ((CO may check CL's neck))
 18 CO: 'kay yeah, okay
 19 (1.7)
 20 CO: .hhh is the first time you've ever been tested?
 21 (2.5)
 22 CO: Whad'ya think?
 23 (2.6)
 24 CL: I donno. mh hhh
 25 (2.3)

- 26 CL: I- (0.2) I kinda kne::w, but (1.3) kinda had da hear it too.
 27 CO: Mm.
 28 (3.0)
 29 CO: What's going through your head right now.
 30 (2.2)
 31 CL: N- nothing
 32 CO: Mm hmm?
 33 CL: Kinda 'n I guess I'm workin' it out I don't know.
 34 (0.2)
 35 CO: Pretty numb?
 36 (2.5)
 37 CL: Yea::h.
 38 (6.0)
 39 CL: Guess it's really not hitting me.
 40 (0.2)
 41 CO: Mm hmm.
 42 (1.2)
 43 CO: Sometimes it takes awhile, for it to kinda sink in. (0.3) even
 44 when you're expecting it.
 45 (2.9)

At a transition relevance place in line 4, CO takes an inbreath and next observes that he did not do CL's 'pretest' (the same counselor usually does both the pretest counseling and post-test informing), which serves as an account for a series of question-answer sequences concerned especially with what I shall gloss as the patient's subjective attitude toward the reported findings. The first two of these sequences (lines 5–7 and 8–10) are about the client's expectations, with the second occasioning inquiry into symptoms (11–18). After this is a query about the number of times tested (line 20), which may be followed by a non-verbal answer (line 21). At line 22, returning to his subjective attitude questions, CO asks what the client may 'think'. CL waits (line 23) before answering, produces a knowledge disclaimer (line 24), pauses again (line 25), and then claims to have known but needing to 'hear it too' (line 26). Once more, CO probes with an attitude question regarding what CL has 'going through' his head (line 29). CL delays and then produces other kinds of disclaimers (lines 31, 33), whereupon CO proposes 'pretty numb' (line 35) as a possibility.

CL confirms this (line 37) and, after a very long silence (line 38), elaborates on this description. Notice that in this and subsequent turns, CO uses the pro-term 'it' several times. Tracking these usages, we can see how they can facilitate movement toward asserting the condition. CL claims (line 39) that 'it's not really hitting me'. With 'it', he is referencing the news, and speaks metaphorically about the difficulty of *realizing* it (Maynard, 2003: Chapter 2). Subsequently, CL displays an understanding of this difficulty by preserving reference to the news and suggesting, also metaphorically, 'it takes a while for it to kinda sink in (0.3) even when you're expecting it' (lines 43–4).

Now the conversation takes a slightly different drift. Following another silence (line 45 above), at lines 46–8 (later), CL proposes a clarification about

what he 'thought'. Midcourse in this turn, the referent of 'it' appears to shift from the news (in 'I've (1.5) thought about it a lot') to the HIV virus itself (in 'could I have it, could I have it (up) in me?').

(9) B68: 52

- 46 CL: Well I've- I've (0.2) already (0.5) I mean I've- (1.5) thought
 47 about it a lot and I (0.3) did kind of (0.3) really think could I
 48 have it, could I have it (up) in me?
 49 (4.7)
- 50 CO: → What does it mean by having it? What does that mean to you that you
 51 → have the virus?
 52 (1.0)
- 53 CL: .h wellhhhh (0.3) at one point it meant I thought I was gonna die
 54 but uh (0.2) apparently that's not true.
- 55 CO: Mm mm.

Then, CO, following yet another long silence (line 49), asks a question referring to the CL's claim about his thoughts ('What does it mean . . .'), and, relative to CL's phrase 'have it', reproducing a version about 'having it', thus also referencing the virus. That 'having it' is alluding to the virus is shown in CO's just subsequent reformulation of his turn-initial utterance; in the reformulation, 'having it' is replaced by 'that you have the virus' (arrows).¹⁵ While this predicative utterance is embedded in a question about its meaning, and is part of a different action than announcing the news (as it would be when the news delivery itself is underway), the counselor has now officially predicated the condition as an attribute of the client. The shift from 'having it' to 'you have the virus', in other words, is a shift from inexplicit reference to explicit reference, from allusive to direct mention of the predicate. And, in his very next utterance, CL ratifies the predicate when he reports what he thought 'it' meant (lines 53–4), where 'it' can tie to and presume having the disease.¹⁶

Thus, citing the evidence at the beginning of this interview – stating that the client tested 'positive' and 'reactive' – is an incipient part of a series of devices to ascertain the client's subjective regard for, and to occasion, the bolder statement that what the tests reacted to was a virus that the client has.

Citing the evidence in internal medicine

Example (9) involves an HIV clinic where counselors are lay volunteers rather than formally trained professionals. This means that the occupational social distance between counselors and clients is not so great as in the DD sessions, where the bearers of diagnostic news are pediatricians or psychologists. Furthermore, counselors deliver the news to the primary figure, rather than, as in the DD clinic, parents or other relatives of the primary figure.¹⁷ The reliance on citing the evidence as a predecessor account to asserting the condition in these two very different clinical environments suggests that this particular ordering of practices may have a generic reach that stretches far. To strengthen this proposal

and anticipate returning to the issue of interaction and institution, I wish to consider a final example.

This excerpt, like all of the data in Peräkylä's (1998; forthcoming) collection, is from an internal medicine clinic. A physician, Dr Hoffman, who has found a patient, Clint Jones, to have stomach cancer, delivers the diagnosis by asking the patient to recollect a 'procedure' in which they put a scope into the patient's stomach and saw something 'growing' (lines 1–2, 5, 8–10, 14 below):

(10) H.J. 57

- 1 Dr H: Do you remember we said we saw something g:ro:wing in your
2 stomach?=
3 Mr J: =Mm hm
4 (0.6)
5 Dr H: D'you remember that?
6 (0.6)
7 Mr J: °Ye:ah i gue:ss.°
8 Dr H: =°Oh kay.° Well that's what we did see:. We- we looked into
9 your sto:ma:ch and we sa::w:: (0.6) right at the spo:t where
10 you feel like (0.2) the food is getting stu:ck,
11 (0.1)
12 Mr J: Mm
13 (1.0)
14 Dr H: .hhh uh::, there is something growing in your stomach.
15 (4.0)
16 Mr J: You can't te:ll what it is?=
17 Dr H: =I can tell you what it is °Clint.°
18 (0.1)
19 Mr J: Mm hm.
20 (0.1)
21 Dr H: → Uh: (0.2) it's a cancer.
22 (0.4)
23 Mr J: °Jhheesuhhs:°

Thus, Dr Hoffman cites the evidence by working to establish a joint 'seeing' of a stomach growth. After a very long silence (line 15), during which Mr Jones leans forward from an upright position and, gazing at the doctor to look down at the floor, he asks 'what it is?' (line 16). With the 'it' referring to the growth, Dr Hoffman preserves that reference (line 21) and hesitatingly announces, 'it's a cancer' (arrow). Here once more is the practice of labeling the evidence – the seeable growth – which can, without explicit formulation, allude to the patient having the cancer as his attribute. Above, Mr Jones responds stoically with silence (line 22), during which he moves his gaze up from the floor and away from Dr Hoffman, and with a very quiet imprecation (line 23).¹⁸

Only much later in the interview, as doctor and patient are discussing treatment options, including surgery, does a predicate assertion emerge. After Dr Hoffman suggests that he will feel better after the surgery, Mr Jones responds by proposing the assertion:

(11) H/J:310

Mr J: → But I still got cancer.
(0.5)

Dr H: That ma:y be the case.

Although Dr Hoffman hedges in confirming this proposal, the exchange suggests again that deliveries in which a clinician labels the evidence can be heard as an allusion to predicating the diagnosis as an attribute of the person. The excerpt shows that in yet another medical environment (see also note 12), clinicians may cite evidence not just because of an interest in sharing laboratory or other findings with patients or family members but as an inexplicit way to predicate a disease as an attribute of the person.¹⁹

Conclusion

Bald assertions of a condition, in relying on unstated or as yet unavailable evidence, are presumptive and confrontational in predicating a disease as an attribute of a person. Consequently, they appear more vulnerable to challenge. At the very least, if challenged, it will be in a similarly confrontational or exposed way, through disputatious negations of the predicate. This is because no firm evidence has been presented that can be resisted in its own right, and the assertion is the only target for contestation. In any case, instead of the bald approach, clinicians are mostly cautious in delivering diagnostic news, and use the two devices of citing the evidence and asserting the condition together, but not in any order. That is, clinicians do not first assert the condition and then cite the evidence to back up what they have predicated as an attribute of a person. Rather, clinicians initially cite the evidence as a predecessor account to asserting the condition, sometimes immediately following the evidence with a diagnostic predicate, and other times alluding to the predicate, or using the evidence to elicit displays of subjectivity that allow tying the predicate to the recipient's own talk.

By citing evidence and asserting conditions in these ordered ways, the interactional accomplishment has different facets. As Peräkylä (1998; forthcoming) argues, because of the separation between testing or examination and delivery of diagnosis, such practices help in achieving intersubjectivity in the matter and in providing a basis for a clinician's authoritative pronouncements.

Yet this does not account for the orderliness in the employment of the practices together, nor for instances of bald assertion that are exceptions to the pattern. First, that clinicians may sometimes assert the condition straightforwardly suggests that there are times and places when, either intentionally or unintentionally, they become presumptive and confrontational with their diagnostic news. Second, that clinicians largely use citations of evidence as a predecessor account to asserting the condition does exhibit an orientation to achieving intersubjective agreement (Houtkoop-Steenstra, 1987), and in this

sense the rather terse references to evidence can embody the authority of medicine (Heritage and Stivers, 1999; Peräkylä, forthcoming).

Additionally, it is important to recognize that achieving agreement is a concrete problem for participants in settings no matter what the more abstract context may be. In ordinary conversation, for actions such as pursuing a response or rejecting invitations, speakers engage in ‘reporting just the facts’ (Pomerantz, 1984b: 158) or ‘detailing circumstances’ (Drew, 1984: 137), such that, as speakers, they are responsible only for the reporting or detailing. In this way, speakers rely on their recipients to see for themselves the import of the facts or circumstances, especially as the upshot (declining an invitation, for example) is dispreferred in a structural sense – treated in the talk by delay, qualification, accounting or explaining, and the like. When they have bad news, deliverers in ordinary conversation also recite facts that are inexplicit rather than explicit about the upshot to be drawn.²⁰ And if the recipient is the primary figure, reporting facts and circumstances allows deliverers to deflect blame from themselves, and to bring the recipient to a state of realization jointly and collaboratively (Maynard, 2003).

In clinics, citing the evidence as a predecessor account to asserting the condition proposes, without being presumptive or confrontational, that a person has a medical disorder and that it is something objectively there as that person’s attribute. That is, the predication of a particular diagnosis as an attribute of the person occurs through interactional work that seeks to achieve a sense of mutuality, understanding, and agreement about such a predicate. And, because the practice of citing evidence on behalf of diagnostic assertions is related to reporting facts and detailing circumstances in other activity environments, an implication is that medical authority, rather than something imposed on the interaction and driving how clinician and recipient deal with one another, instead is something that is ‘helped along’ by structures of interaction that these participants produce in real time according to generic procedures of establishing the official basis for consequential upshots. In a variety of places, and especially when some outcome in the world has a negative valence or is dispreferred, those who are presenting that outcome to others work carefully through their practices of talk-in-interaction to establish its objectivity – its visibility not just for the speaker but for anyone including the recipient. Medical and other forms of authority may be built upon such practices.

ACKNOWLEDGEMENTS

The author thanks two anonymous reviewers for this journal and Anssi Peräkylä for comments on a previous version of this article.

NOTES

1. There are other aspects to Peräkylä’s (forthcoming) analysis. For example, he shows that when the physician is uncertain or a patient’s views are discrepant

with the physicians', that also may result in explication of evidence for the medical diagnosis.

2. On this balancing act, also see Gill (1998), Halkowski (forthcoming), and Heritage (forthcoming).
3. Peräkylä also examines a third device that he calls 'inexplicit references to the evidence', which means alluding to sensory evidence (e.g., 'there appears to be an infection at the contact point of the joint'). In Peräkylä's data, this device is relatively rare. In my data, inexplicit reference is also rare, and usually indicates uncertainty deriving from the testing process. See note 7 below and, for a more extensive consideration of uncertainty in diagnostic news deliveries, see Maynard and Frankel (forthcoming). In this article, I concentrate on the two practices of citing the evidence and asserting the condition in cases where clinical certainty of diagnosis is displayed as strong.
4. Thus, the clinicians and recipients in my data largely regard the news that is delivered as 'bad' news. To compare these deliveries with disconfirmations of medical conditions ('good' news) entails complexities that are not possible to address herein. However, see Maynard (2003: Chapter 6) and Maynard and Frankel (forthcoming).
5. I use 'primary figure' to refer to the individual whom the news most directly affects or for whom the news is most consequential. Secondary consequential figures are related in various ways to the primary figure and affected by the news but not as directly. See Maynard (2003: Chapter 5).
6. 'NY22' and similar designations are case numbers.
7. These examples are from cases where clinicians otherwise display diagnostic certainty. That is, the hedging, rather than indicating the clinician's uncertainty or indeterminate findings, reflects interactional considerations. When testing is indeterminate, clinicians may articulate the diagnosis along the lines that Peräkylä (forthcoming) terms 'inexplicit reference'. For instance, in one interview (NY19), the pediatrician told a mother that her son's brain wave test was 'normal'. He then explained that the test is unreliable in the sense that it can identify abnormalities in normal children and miss them in children with brain damage. Thus, the pediatrician remarked, 'There's no way for sure that we can say to you that Pete is or is not brain damaged . . . All we can say is that on the basis of our experience, he probably is.' Later this formulation is produced (normalized transcript):

Dr: And that's why labels are so dangerous. So we can call him a child with some kind of brain syndrome. It's you know there's a book that lists all the diagnoses and you write it down, organic brain syndrome, it means that you think that there is some kind of brain damage. Doesn't mean 'you know' it just means 'you think'.

There is an assertion of a condition when the pediatrician says, 'we can call him a child with some kind of brain syndrome.' And slightly later, he says, 'Or we can call him something which you will hear about, called minimal brain dysfunction.' By formulating the diagnosis as something to *call* the child, the pediatrician in this interview is refraining from firmly declaring the child *to be* brain damaged. Based on indeterminate test results, the condition is predicated of the child in a tentative fashion.
8. All personal names used in the discussion of cases and excerpts are pseudonyms.
9. For more extensive consideration of this case and excerpts from it, see Maynard (1989, 2003: Chapter 3).
10. Notice that the turn is built as an addition ('And . . .') to the previous talk and has the assertive format identified earlier.

11. See Schegloff's (1996: 184) analysis of a particular form of allusive talk, and particularly his discussion of intentionality. Not all forms of 'implicit conveyance' of a message are necessarily intended to be allusive, but Schegloff argues that when a recipient of allusive talk formulates the referent more explicitly, and the recipient of this formulation confirms it by repeating it, that does indicate a 'prior orientation to convey' the explicit version. In the data here, rather than the confirmation of the explicit formulation being a repeat of it, the confirmation is an agreement term ('yes'). Nevertheless, Mrs Rivers, in her query, says, 'are you tryin' ta tell me . . .'. Consequently, in confirming her proposal, Dr Yost also confirms his intention to have conveyed the predication.
12. Excerpts (5) and (6) are from the developmental disabilities clinic. However, in medical literatures on bad news, it is readily possible to find other examples of the practice of citing test results in a way that elicits an assertion of condition from the recipient. Here is just one from a breast cancer clinic (Taylor, 1988: 118):

Pt: Did you get my report back?

Dr: Yes, as a matter of fact, I have the [pathology] report here somewhere on my desk. Let me see [reaching over to pick up a slip of paper from a pile]. Ah yes, it says, 'infiltrating and intraductal lobular carcinoma, well encapsulated in . . .'

Pt: You mean – it is – I've got – cancer?

Dr: Yes.

Pt: Are you sure?

Dr: Yes, I went down and checked in the lab . . .

Notice also the patient's change from 'it is . . .' to 'I've got cancer', which is a move from a more euphemistic way of predicating the diagnosis to a clear assertion (see also excerpt 7). Then the doctor confirms the assertion.

13. Here, I mean that Dr Meyer, by suggesting that 'you're:: not optimistic that the kid's going to catch up' is speaking generically. Both *you* (in 'you're:: not optimistic') and the *kid* (in 'the kid's [not] going to catch up') can be heard as categorical and not personal reference forms.
14. ELISA is an acronym for Enzyme Linked ImmunoSorbent Assay.
15. Notice also that 'What does it mean' is replaced by 'What does that mean to you . . .' The alteration in this preface is posing the question as less abstract and more personal.
16. On the way that pro-terms can tie to previous-turn predicates, see Sacks (1992: 150–6).
17. Because children, and particularly those with developmental disabilities, may not be yet considered as fully competent participants in social life, parents may stand as virtual primary figures in the news delivery process.
18. This excerpt is analyzed extensively in Maynard and Frankel (forthcoming).
19. Earlier I remarked that confirmations of disease are regarded as bad news, which implies that disconfirmations are good news. But this is not always the case. Sometimes patients or family members may look to confirmations of disease as legitimizing their having sought health care, or their requesting therapeutic intervention through prescriptive medication. Then, disconfirmation is bad news (Heritage and Stivers, 1999: 1507). In such cases, the diagnostic announcement may have a negating preface, such as '(I'm) not really convinced' (see lines 10–11 below), to be followed by the predicate assertion, 'you have an ongoing infection' (line 11).

(Heritage and Stivers, 1999: 1509)

1 Doc: °(Well) let's check your sinuses an' see how they look today.°

- 2 (1.0)
 3 Doc: That looks a lot better=I don't see any inflammation today.
 4 (0.8)
 5 Doc: G[ood.
 6 Pat: [(Good.)
 7 (.)
 8 Doc: That's done the trick.
 9 (1.0)
 10 Doc: So you should be just about o:ver it. I don't- (I'm) not really (.)
 11 convinced you have an ongoing infection=it seems like the augmentin
 12 really kicked °it.°
 13 Pat: Good.
 14 Doc: O:kay. (.) An' what else did we need to address your EKG:?

The pattern here involves using evidence – the 'online commentary' at line 3 – as a predecessor account to this assertion. For the fuller analysis, see Heritage and Stivers (1999). Thus, disconfirmations of disease also may be fitted to the careful practices of diagnostic predication.

20. For an example in which a father conveys news to his son about the wife's or mother's cancer, see Beach (2002) and Maynard (2003: 136–7).

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