TELLING THE STORY: THE STATUS OF ACCOUNTS DESCRIBING THE DEATH OF A SPOUSE

Moira Josephine Kelly

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Abstract

This is an ethnomethodological study of qualitative research interviews concerning the death of a spouse. The focus is on the accounting practices of interview participants. Methods of analysis described by Sacks, membership categorisation analysis (MCDA) and conversation analysis (CA), have been applied to the data. The analysis also draws on Sacks's discussions of storytelling.

Three different but related issues are examined in the data: criticism of health professionals, assessment work and doing interview talk. MCDA has been used to document how criticisms of health professionals are produced and to examine how assessment work is done. Criticism involves setting up lay and professional identities, and recipient-design. Interviewees venture their criticisms cautiously, setting up their accounts in such a way that the hearer is co-implicated.

A feature of the detailed assessment work undertaken in the accounts is the setting up of entitlements to certain experiences by interviewees, such as being with a spouse when they die. The way in which the identities of the speakers in the (interview) talk are established in the opening turns has been examined using CA. The opening request by the interviewer, 'could you tell me the story of what happened' is produced as an open-ended question but the response provided is skilfully tied to a story that the interviewer expects to hear.

Implications of the analysis are drawn regarding the status of interview data. The value of attending to the accounting practices of participants in producing interview data is also discussed in relation to lay assessments of health care.

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PART ONE: INTRODUCTION

This section will introduce the thesis, describing the topics it covers, methodology and the research process. It contains two chapters: an introduction to the study, and a natural history of the research.

Chapter One will locate the study in terms of its theoretical background, methods, aims, and the research problems addressed. The structure of the thesis will also be outlined. Chapter Two will provide an overview of the process of the research, methodologically and in relation to the research problems examined. This includes an overview of the evolution of the study through a number of phases.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This study is a sociological analysis of research interview data. Interviews are one of three basic methods of social research, described by Dingwall (1997) as 'asking questions', 'hanging out', and 'reading the papers' (p53)[1]. They are usually treated by social researchers as a way of collecting information on people's experiences, views, and attitudes regarding particular social issues. They take various forms, from structured questionnaires to biographical life history approaches. As discussed in Section 1.4 below, there are a number of different ways in which interviews can be analysed.

The data for this dissertation were collected as part of a research project that aimed to compare hospice and hospital care for people who had died from cancer and their spouses. The project was carried out between October 1994 and September 1995 and was directed by Clive Seale at Goldsmiths College. The main research project included the collection of quantitative and qualitative interview data. This thesis is a study of part of the qualitative data. It takes Baruch's (1981; 1982) ethnomethodological study of qualitative interviews with parents of children with medical conditions as a starting point for analysis.

Following Sacks's (1963) discussion of the relationship between 'sociological apparatus and sociological subject' (p1)[2], the aim is to produce 'sociological description'. Sacks makes a distinction between analyst's and members' concerns. He argues that, as scientists, whatever we take as our subject matter must be adequately described. This

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[1] Dingwall comments that he once heard a distinguished anthropologist (unnamed) say that there are just the first two. He adds the third. Dingwall does not mention audio- and video-taping data. However, it is taken here to be included in what he describes as hanging out or observing social situations in situ. Silverman (2001) refers to 'recording and transcribing' as a separate method (p11).

[2] Sacks takes Durkheim's study of suicide as a starting problem. The difficulty Sacks has with Durkheim's study is that suicide as a category had not been adequately described in terms of 'the procedure employed for assembling cases of the class' (p8).

means taking practical theory and commonsense knowledge used by members (of the social world) under study as our object of analysis. According to Sacks description should be produced which treats commonsense categories not as sociological resources, but as features of social life:

> ...even if it can be said that persons produce descriptions of the social world, the task of sociology is not to clarify these, or to 'get them on the record', or to criticize them, but to describe them. That persons describe social life (if they can be conceived as doing so) is a happening of the subject quite as any other happening of any other subject in the sense that it poses the job of sociology, and in contrast providing a solution to sociology's problem of describing the activities of its subject matter. (1963: 7)

Such detailed attention to describing the way in which social phenomena are constructed by participants will eventually lead to generalised description and an orientation to practical significance (Sacks, 1963)[3].

1.2 The study data

In the study directed by Clive Seale 70 interviews were undertaken with bereaved spouses in South London[4]. There were 35 interviews with spouses whose husband or wife had died in hospice, and 35 interviews with spouses matched by age and sex, whose husband or wife had died in hospital. The sample was drawn from death certificates of all those who had died from cancer approximately six to nine months beforehand. These were kept at local Departments of Public Health and ethical committee approval was obtained from the three health authorities covered. Each interviewee was written to (see Appendix 1), and asked to take part in the study. I called round to their house a couple of days after the letter had been sent and asked to interview them. Written informed consent was gained prior to all the interviews. The main findings from the study are

[3] Garfinkel (2001) also argues that ethnomethodology's project is the same as that of classical or mainstream sociology, to attend to the concerns of social structure through 'Working out Durkheim's aphorism'. How it differs is in the way it approaches the problem of sociological description.

[4] The mean ages of the interviewees and deceased were 69 years and 70 years respectively. Sixty-one per cent of the interviewees were female.

written up elsewhere[5]. Sixty-five of the interviews were tape recorded with the consent of the respondents.

As with many PhD studies, I had the practical constraint of needing to use the data available to me[6], which led me to examine interviews with people who had cared for a spouse who had died from cancer. The interviews were started with an open-ended question, 'tell me the story of what happened'. The intention was that, for this part of the interview, there would be minimal interruption by the interviewer (MK), allowing the respondents to structure their own accounts. The response to this request, the initial 'story', constitutes the data for my PhD study. The rest of the interview followed a semi-structured format involving a series of questions. I refer to the data analysed here as interviews, though the analysis is based on the first part of the interview only, up to the end of the story.

1.3 Case study approach

As with the majority of qualitative research studies, a case study approach has been adopted regarding the selection and analysis of data. The case study is used in a wide variety of ways by qualitative researchers (Hammersley, 1992). Hammersley suggests that the term 'case' is to be taken to be: 'the phenomenon (located in space/time) about which data are collected and/or analysed, and that corresponds to the type of phenomena to which the main claims of a study relate' (p184). The development of theory is central to case study research. As Mitchell comments:

[5] See Seale and Kelly (1997a; 1997b) for a detailed description of the sample and findings from the main study.

[6] This is demonstrated by Silverman (1987) who describes the background to the research he and his research assistants carried out on doctor-patient communication. It was decided to include an interview study in the larger research project primarily to please the funders. It was through this process that Baruch's interview data was collected.

> ...the 'case study' refers to an observer's data; i.e. the documentation of some particular phenomenon or set of events which has been assembled with the explicit end in view of drawing theoretical conclusions from it.... What is important is not the content of the case study as such but the use to which the data are put to support theoretical conclusions. (1983: 191)

This has implications for the selection of the data 'sample'.

Sandelowski (1986) distinguishes between two types of sampling, selective and theoretical. Selective sampling is the decision made at the beginning of a study to sample subjects according to a preconceived, but reasonable, set of initial criteria[7]. Theoretical sampling, on the other hand, is sampling made on analytic grounds as the study develops. As Mitchell suggests:

> ...the extent to which generalisation may be made from case studies depends upon the adequacy of the underlying theory and the whole corpus of related knowledge of which the case is analysed rather than on the particular instance itself. (1983: 203)

Three separate but related pieces of analysis have been undertaken over the course of the research, which are roughly labelled as 'criticism of health professionals', 'assessment work' and 'interview talk'. However, they are treated as an integrated whole for the purposes of the thesis, addressing the aims set out at the end of this chapter. This thesis is therefore considered as a case study analysis of qualitative interview accounts, which is made up in turn from three different pieces of analysis.

The detailed level of analysis involved in examining participants' practices in the talk has meant that the empirical analyses of criticism of health professionals and assessment work have drawn on the first five interviews only (Chapters Three, Four and Five)[8]. Analysis of the construction of the talk as the interview has drawn on 25 interviews,

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[7] Selective sampling is undertaken in survey research where variables are pre-set. It is also the case in a great deal of qualitative research which aims to find out about a particular topic, e.g. experiences of lung cancer. This will mean that people with lung cancer or who have been in contact with people who have it will be 'sampled'.

[8] Summaries of these five interviews can be seen in Appendix 2, page 312.

with additional interviews (to the five initially analysed) being selected on the basis of emerging theory (Chapters Six and Seven).

Decisions about the selection of the sample have not been pre-set, but have been conceptually driven by the theoretical framework underpinning the research from the start (cf Curtis et al., 2000). In order to undertake analysis that addresses the adequacy of the underlying theory described by Mitchell above, decisions about the sampling of data have been made during the research. This has been influenced by the two different ethnomethodological research methods which have been applied to the interview data. Analysis of communicative practices (in the interview accounts) can only be discerned in 'the fine grained detail of talk-in-interaction' (Drew, 2001: 267). I have set out to undertake the fine grained analysis recommended by Drew and also to make comparisons across cases, using both intensive and extensive analysis where appropriate to my research problem[9].

1.4 Theoretical orientations

The contemporary popularity of the interview in qualitative research can be seen both in the proliferation of studies using the interview as a method for collecting data, and in research texts and papers discussing different approaches to design, data collection, analysis and interpretation[10]. The frequent selection of the interview as a method in research studies is a reflection of its commonality as a form and expression of social life (Atkinson and Silverman, 1997). This is exemplified in a recently published text, *Handbook of Interview Research,* edited by Gubrium and Holstein (2002a), containing 44 chapters on different forms of interview research, the majority of them qualitative. The editors comment:

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[9] Some conversation analytic research in which sequential formats are identified involve large data sets (for example, see Heritage and Stivers, 1999; Heritage et al., 2000). This is harder to do in relation to the categorisation work done in talk.

[10] Examples of a wide range of qualitative interview research studies and discussions of methodology can be seen in journals such as *Sociology of Health and Illness, Qualitative Inquiry,* and *Social Science and Medicine.*

> The interview itself has created, as well as tapped into, the vast world of individual experience that now constitutes the substance of everyday life. (p9)

On a theoretical level qualitative interview researchers appear to be aware of the constructed nature of accounts. This awareness has been influenced by the increasing regard given to issues of 'representation' in empirical research, which is clearly reflected in methodological discussions of interview research[11]. Such discussions draw attention to the problems associated with interview data, such as the influence of the interviewer on the data (for example, see Grbich, 1999; Mason, 2001). There is considerable recognition in research texts and papers that accounts are co-constructed (see Cicourel, 1964; Mason, 2001; Mishler, 1986; Oakley, 1981; Rapley, 2001a) and locally situated (see Cicourel, 1964; Holstein and Gubrium, 1997). However, although these issues are raised in research texts, they are rarely adequately addressed in empirical research papers[12]. This has implications for how the data and analysis are to be treated and used and what implications can be drawn.

The large majority of funded interview studies are commissioned and carried out in order to say something about the topic of interest and make policy recommendations on the basis of the findings. In this sense they may be *treated* as a primary, rather than a secondary, data source. This can be seen in the way the findings from interview data are discussed in two recent research papers. Coyle (1999) makes the following comment regarding her analysis of interviews about dissatisfaction with health care:

> A whole range of problems in health care, from practitioners failing to listen or take the concerns of the patient seriously, to clinical problems of misdiagnosis, to difficulties in gaining access to services, were interpreted by respondents as threats to personal identity and as undermining their

[11] This can be seen in the majority of recent research texts that include the interview as a method (for example, see Gubrium and Holstein, 2002a). Atkinson and Silverman (1997) also highlight and discuss some of the critical readings of the interview and the data it yields.

[12] Researchers are beginning to formally recognise the role that the interviewer plays in structuring the talk (even when attempting to produce a 'free telling' (Mazeland and ten Have, 1998)). For example, see Mishler (1986). However, attention to how the talk is constructed as interview is usually limited in sociological studies. This can be seen in the way that research reports and papers do not usually include interviewer utterances. Topic guides may be included, but these do not accurately represent how topics may be raised, or questions asked.

> sense of self. The implications for professional practice are that practitioners require [sic] to be sensitive to the issues of personal value and worth, and understand how their work and manner contribute to, or undermine, patients' self worth. (p118)

Similarly, Kutner et al. (1999) comment on the perceived value of using open-ended interviews to research information needs in terminal illness:

> The use of initial open-ended interviews to explore the important issues allowed us to formulate relevant questions and discover what were truly concerns to this population. The conclusions were based on actual patient experiences, not speculation in reaction to scenarios. (p1351)

In both of these research papers, the way the data are described indicates that the interview accounts are treated as a primary source. In Coyle's study the assumption is made that the problems with practitioners exist in the way in which the interviewees describe, and policy implications are suggested on that basis[13]. Kutner et al. consider the views expressed by the interviewees to represent their 'true' concerns. Treating the data in this way attributes a status to it that it is difficult to validate. The potential for interview data to be unproblematically attributed a certain status, regarding the validity and reliability of the data and analysis, highlights the need to consider its theoretical underpinnings.

The interview is a research method, but it is more than just a way of collecting data. It is also theoretically important (Ackroyd and Hughes, 1992). Data are collected in order to consider theoretical questions, and methods of data collection 'instantiate theories of their own which serve both as legitimators of the method and as justifications for the method doing the job it is intended for' (Ackroyd and Hughes: p183). This implies that Coyle and Kutner et al.'s assumptions are theoretically saturated but their accounts represent rather than constitute reality. Methods should therefore not be treated as

[13] My point here is not that Coyle's analysis is in itself invalid, but that the claims she makes for it present a problem. The issues arising from this will be discussed further in Chapters Three and Nine.

'atheoretical tools' (Ackroyd and Hughes: p183). The theoretical approach to the data will influence claims that can be made, and has implications for validity.

1.4.1 Idioms of qualitative inquiry

Qualitative interview studies can be undertaken from a number of theoretical perspectives. Gubrium and Holstein (1997) identify four 'idioms of qualitative inquiry': naturalism, ethnomethodology, emotionalism, and postmodernism[14]. They discuss the differences and similarities between these idioms, which may at times be seen as competing. However, as they point out, although methods may differ in their focus, 'qualitative researchers maintain an abiding interest in interactional complexity' (p13)[15].

Let us briefly consider the nature of naturalism, emotionalism, and postmodernism in relation to interview research, before moving on to a more detailed discussion of ethnomethodology and how it can contribute different understandings of social phenomena. It should be noted that my intention here is not to discount other approaches, but to demonstrate how ethnomethodology can contribute different insights into interview research.

Naturalism seeks to describe people and interaction in the places where they live, work and spend leisure time. Meaningful reality is located in the immediate settings of people's daily lives. Participant observation and ethnographic analysis are used to observe people in 'naturally occurring' settings. Interviews may be collected as part of

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[14]Gubrium and Holstein consider the 'relationship between research and the idioms in which it is conducted' (ix). There is a great deal of overlap between different idioms. Gubrium and Holstein differentiate between idioms and theoretical paradigms, including symbolic interactionism. They argue that symbolic interactionism has considerable diversity in application and orientation which is expressed within the four idioms they discuss. It is also to be noted that researchers may not use these labels themselves.

[15] Gubrium and Holstein (1997) draw attention to the common threads across qualitative research. They propose that these form the basis for articulating a 'new language of qualitative inquiry' that has been emerging for some time. This new language is 'increasingly conscious of its empirical claims' (p15) and attention to questions of *what* and *how* albeit from different vantage points. However, they warn against overemphasis on the 'procedural self-consciousness' that has merged through postmodernism, arguing it has potentially detrimental implications for empirical analysis (in the sense that empirical inquiry could be overwhelmed by concerns of representation).

the research, though this is usually as an addition to observational data. The interview is seen as a way of finding out more than observation can reveal about people's experience, e.g. their views and feelings about health. This is seen to add depth to observational data. The study by Glaser and Strauss (1965) of dying in hospital is an example of a naturalist approach. They emphasised that theory was developed during the course of the research, and 'grounded' in the experiences of research participants. There is therefore an interest in subjective viewpoints, as well as observations of people and events.

The interests of naturalists overlap with that of emotionalist researchers. However, emotionalists go a step further in taking the subjective experience of individuals as their primary focus, 'seeking to reveal the depths of feelings' (Gubrium and Holstein, 1997: 63). Interviews are one of a number of conventional and unconventional methods (including techniques such as writing and art) that may be used to collect data on emotional experience. Emotionalist studies span a range of research where involvement between the researcher and subject is emphasised rather than discouraged. Oakley's (1981; 1986) interview study of becoming a mother can be regarded as an example of emotionalist research. She argues that the personal involvement of the interviewer, including the sharing of experiences, is an essential part of conducting such interview research. Douglas (1977; 1985) goes further than Oakley, emphasising methods that include active elicitation of affective reactions to events by research participants[16].

The role of postmodernism as an idiom of qualitative inquiry takes the form of a challenge to researchers to consider how sociological texts are constructed. Given that there are multiple possible realities that may be created, the relationship between 'researcher, representational practice and those studied' needs to be considered (Gubrium and Holstein, 1997: 10). The practices of the researchers themselves are examined critically in terms of the construction of events described.

[16] Douglas (1977) has particularly criticised ethnomethodology for its emphasis on the structure of accounts and (as he sees it) active exclusion of emotional aspects of experience.

There are both similarities and differences between naturalism and emotionalism in the way they treat qualitative interview data. Here my interest is in demonstrating the difference between these methods and ethnomethodology which has quite a different take on interview data.

1.4.2 Ethnomethodology

The term 'ethnomethodology' was initially used by Garfinkel (1967) to describe the activities by which members (of society) produce and manage the settings of organised daily life[17]. Following Schutz (1962; 1964; 1966), he takes the position that social interaction presupposes a world that is known in common, and intersubjectively shared by its members[18]. Commonsense knowledge of social life for members of society is institutionalised knowledge of the real world (Garfinkel, 1972). He states that:

> Members' accounts are reflexively and essentially tied for their rational features to the socially organised occasions of their use for they are *features* of the socially organised occasions of their use' (p4).

Garfinkel outlined a number of ideas that are key to ethnomethodology: topic and resource; the documentary method of interpretation; and the use of indexical as opposed to objective expressions.

As with Sacks, Garfinkel differentiates between lay and sociological analysis of social situations. This means that, as discussed in Section 1.1, practical commonsense circumstances and reasoning are to be treated as topics of study rather than resources. Members search for patterns of meaning and produce these as a 'document' of their interpretation of events. A range of contextual factors and assumptions are set into

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[17] See Garfinkel (1967) for more detailed description of his arguments regarding ethnomethodology. Also see Heritage (1984) for a comprehensive critique of Garfinkel's work on ethnomethodology.

[18] The term 'member' is commonly used in ethnomethodology and is a way of referring to people as members of the social world. For the purposes of research the distinction between interviewers and interviewees is not pre-judged. In this thesis I at times use the terms member, participant, and actor inter-changeably.

action to produce and sustain a 'documentary version' of a sequence of events. Such accounts make events observable and reportable. Accounts are therefore 'reflexive' (in that they demonstrate the way in which members choose between a range of options for action), and indexical because they depend upon members invoking some local context. The study of practical reasoning by members means that we can study both what the rules of social interaction are, and crucially for applied researchers (such as myself), how they are used.

Ethnomethodology is about explicating the concerted work actors do to make social factors observable and accountable to one another in their everyday lives (Maynard and Clayman, 1991). Garfinkel demonstrates how people actively engage in producing social institutions, accomplishing social context routinely through ordinary, everyday practices. In this sense, institutions such as the family, work, and health care can be seen to be locally constructed rather than having a pre-set existence, always retaining the same characteristics and functions. What distinguishes ethnomethodology from other research that can be described as 'social constructionist' is that it focuses on the local production of social structure through the micro-analysis of social interaction, particularly talk[19]. Phenomena such as power are not assumed. This will be demonstrated in more detail through application to the data in later chapters. It is also discussed in Chapter Eight and Nine, in relation to the status of the qualitative interview accounts.

[19] Critical discourse analysis (CDA) is also a constructivist method and appears to have similarities with ethnomethology. However, the central concern of CDA is the way in which aspects of social structure, such as gender and class, influence social relationships. Schegloff (1997) presents an insightful argument, drawing on empirical analysis, of the importance of grounding analysis in use of context by participants (in talk), rather than importing it as in CDA. This paper has stimulated considerable debate about the relative merits of CA and CDA regarding the role of context in analysis (see Billig, 1999a, 1999b; Schegloff, 1998, 1999a, 1999b; Wetherall, 1998).

The distinctive way in which ethnomethodology treats interview data is in line with the general points outlined in Figure 1.1 below[20]. Although there are differences between naturalism and emotionalism in terms of their analytic interests, they are similar in their treatment of the data as a 'resource'. There is an emphasis on the subjective meanings used by people to interpret their actions. Open-ended questioning is preferred as a way of obtaining information about attitudes and actions, with interviewees being encouraged to communicate their underlying attitudes, beliefs and values.

[20] This brief overview of qualitative idioms is a simplistic representation, and may give the impression that the view taken here is that qualitative researchers are naïve about the interactive nature of interviews. This is not my intention and it would be inappropriate to suggest that this is the case. As discussed above, most contemporary texts discussing interview research, such as those by Mishler (1986), and Ackroyd and Hughes (1992), acknowledge the way in which the context of the interview will influence the data produced. However, I suggest that although this may be recognised in research texts and papers, in practice it is not generally attended to in the analysis or is thought to be avoided by following certain prescriptions of 'good practice'. With this in mind, my intention here and throughout the thesis is to demonstrate the way in which ethnomethodological analysis of *how* qualitative interview accounts are constructed can offer different and helpful insights into social problems.

	Naturalism/ Emotionalism	Ethnomethodology
Relationship between interviewee and interviewer	Interviewer elicits experiences, views and attitudes from the interviewees	The interview is collaboratively constructed by both participants
Nature of data	Account of interviewee's personal experience, views and attitudes	A locally constructed account
Analytic categories	Imposed by researcher	Members' categories are described. Distinction between members' and analysts' categories is made explicit.
Reflexivity	Interviewer's relationship with interviewees is described	How interview participants construct identities within talk (interviewer is a participant)
Treatment of the data	Interview as resource	Interview as topic

Figure 1.1 - A comparison of naturalism/emotionalism and ethnomethodological approaches to the analysis of interview data

1.4.3 Interviews as a data source

Naturalism and emotionalism involve treating interview data as a sociological resource available for analysis, rather than the topic of analysis. The information provided by the interviewee is usually treated as the data. In this sense it is treated as a primary source of information about the events and experiences described. Ethnomethodologists view this as problematic, and regard interviews as an unreliable source of information about what actually happens in the situations described. For example, a description of health care produced in an interview cannot be treated as a straightforward report of that care. Treating the data as a primary source in this way can be potentially misleading. This issue is complex and the theoretical and practical aspects will be discussed further following the data analysis (in Chapters Eight and Nine).

Ethnomethodology treats the interview as a locally situated, recipient-designed account. The interview itself is the naturally occurring data, or topic under investigation. It is analysed in terms of the way it is constructed by participants. In this way, the data is treated as a primary source for the purposes of understanding how the accounts are constructed. This can then lead to treating the data as a secondary source, in seeing how the various methods used in the talk by participants lead to the construction of topics of interest to applied researchers (here sociologists of health and illness).

This has implications for the way in which categories are used in the data analysis. Naturalism and emotionalism involve using analytic induction and the constant comparative method to identify a series of categories which arise out of the data, and are therefore grounded in, or representative of, the experiences of the interviewees (Glaser and Strauss, 1967; Silverman, 1993). These categories are interpreted and developed into theory regarding the topic under investigation[21].

Ethnomethodology takes induction a step further by setting out to explicate the categories members use in their talk, and how they are generated and used to carry out

[21] This can be seen in studies such as Glaser and Strauss's (1965) research on awareness of dying in which a series of 'awareness contexts' were identified, such as 'closed awareness' and 'suspicion awareness'. These are researchers' categories developed inductively from the data.

social activities. However, attending to members' categories is not a case of using the lay person's language to do the work of the social researcher. An explicit distinction is made between analyst's and members' categories. This is explained by Sacks:

> The 'discovery' of the common-sense world is important as the discovery of a problem only, and not as the discovery of a sociological resource (1963: 11).

Ethnomethodological researchers do not usually choose to undertake or analyse research interviews as a way of collecting data for subsequent analysis. As with naturalism, they generally prefer to use data from naturally occurring settings (Silverman, 2001). Here the interview data is to be analysed as naturally occurring talk. The intention is to investigate the way in which interview participants collaboratively set up, select and use resources in their talk to do particular social activities. It is not assumed at the start what those social activities may be.

1.4.4 Reflexivity

Reflexivity is conventionally defined as 'the capacity of researchers to reflect upon their actions and values during research, whether in producing data or writing accounts' (Seale, 1998: 329). It has been a concern for qualitative researchers since its inception and many attempts have been made to analyse 'the intimate relationship between the research process and the findings it produces' (Altheide and Johnson, 1994: 486).

The notion of reflexivity is considered differently in ethnomethodology. Research accounts are taken to constitute the world they describe (Garfinkel, 1967), meaning that the analyst cannot remove himself or herself from the moral order in order to talk about it (Jayyusi, 1991). Context is embedded in the talk-in-interaction and is a problem for members as well as for the analyst. Importantly, the way in which context is set up by participants in the data is described and is a feature of the analysis, rather than something that is to be considered separately. As Heritage (1984) comments in relation to Garfinkel's work:

> It is via the reflexive properties of actions that the participants – regardless of their degree of 'insight' into the matter – find themselves in a world whose characteristics they are visibly and describably engaged in producing and reproducing. (p110)

> Like other actions, descriptions are 'indexical' and are understood by reference to where and when etc. they occur. Like other actions too, descriptions are 'reflexive' in maintaining or altering the sense of the activities and unfolding circumstances in which they occur. (p140)

The notion of reflexivity is therefore treated as an analytical concern. The aim is not to *reflect* upon the possible role the researcher may have in the production of the research, but to produce an adequate sociological description of members' practices in the data.

In interview data the interviewer's actions are also treated as part of the data[22]. The interviewer's involvement in the production of the talk is analysed both through his or her active involvement in the talk, and through the use of recipient-design by the interviewee. The analytic relevance of attending to these concerns, i.e. of distinguishing between members' and analyst's accounts, and to consider the data as a collaborative production, is demonstrated in the analysis of the interview data. The relationship between the researcher and the topic of study is also addressed through the principle of 'ethnomethodological indifference'.

1.4.5 Ethnomethodological indifference

The aim of ethnomethodology as set out by Garfinkel, is to bracket conventional social forms so that different kinds of questions can be asked, and the things we take for granted, our 'background expectancies', can be identified. The task of sociological description in the sense described by Sacks (1963) and Garfinkel (1972) is not a simple one. In order to produce adequate description of this type, it is necessary to adopt a policy of ethnomethodological indifference:

> Ethnomethodological studies of formal structures are directed to the study of such phenomena, seeking to describe members' accounts of formal structures wherever and by whomever they are

[22] It is noted that the analyst may not be the interviewer.

> done, while abstaining from all judgments of their adequacy, value, importance, necessity, practicality, success, or consequentiality. We refer to this procedural policy as "ethnomethodological indifference". (Garfinkel and Sacks, 1970: 345)

This does not mean that interpretive judgements about adequacy or consequentiality cannot be made. This is part of the process of qualitative research. However, they are to be made after the analysis of members' methods has been carried out, so that a distinction can be made between members' and analyst's work.

1.5 Methods of analysis

Up to this point I have described the relative position ethnomethodology takes within qualitative inquiry and its general principles, but I have not shown how such analysis is to be carried out. How are we to ask and answer the different kinds of questions that are made possible by ethnomethodology?

Garfinkel's *Studies in Ethnomethodology* (1967) was a central text in setting the course for ethnomethodological research. However, his research primarily takes the form of experimental studies rather than examining how social interaction is conducted in naturally occurring settings. He does not provide a systematic way of analysing data. Fortunately, Sacks (1992) provides us with two different, but related, methods that can be used to conduct detailed study of social interaction: membership categorisation device analysis (MCDA), and conversation analysis (CA). Since Sacks's untimely death in 1975, these approaches have been developed and applied relatively independently of each other, with CA being by far the more popular of the two. I have applied both of these methods to my interview data.

MCDA and CA are presented and discussed in depth in a number of methods texts and research papers. As well as the work already mentioned by Sacks (1992), there are a number of useful texts available that describe MCDA (see Jayyusi, 1984; Lepper, 2000; Silverman, 1998a). In comparison, the body of CA papers, books, and methods texts is extensive (see ten Have, 1999; Hutchby and Wooffitt, 1998; Silverman, 1998a). A brief

overview of MCDA and CA, focussing on the aspects relevant to my data analysis, will be provided here as a background to the empirical chapters. The section below on CA is shorter as it is considered to be more appropriate to describe its application in the data chapters (Chapters Six and Seven).

1.5.1 Membership categorisation device analysis

Membership categorisation device analysis (MCDA) is the primary method I have used to analyse the data. Sacks (1992) suggests that the business of the sociologist is to try to construct the machinery that would produce actual occurrences, in this case the interview accounts of bereaved spouses. He argues that when people do description, they use categories from a collection, e.g. family (mother, father, children) or health professionals (hospital doctor, nurse, GP). This is called a membership categorisation device (MCD). A collection will contain at least one category that may be applied to a population containing at least one member. Using rules of application the collection of membership categories provides for the pairing of at least one population member and one categorisation device member. An MCD is then a collection plus rules of application (Sacks, 1972). Sets of categories are 'inference rich' in that they store a great deal of the knowledge that members have about their society. Members generate and use categories in their descriptions such as here, when interviewed about the death of a spouse. Description is done through selection of particular categories and the setting up of particular rules (social norms) regarding their use. MCDA provides an effective way of systematically analysing accounts, which makes it possible to substantiate without imposing analyst's definitions[23].

Sacks suggests that if we want to describe members' activities and the way they produce and organise them, we need to establish how they choose among the available category sets for grasping some event. This is demonstrated by Drew (1978) who looks at the way in which descriptions of locations are critical resources in the formulation of talk (regarding the Scarman report) into a description of witness' action (p4). He comments:

[23] As happens when applying methods such as content analysis.

> ...for members an initial problem in depicting persons in a setting is the selection of *relevant* categories with which to describe persons, given that some selection(s) may not be relevant for the task at hand, but may lead to misunderstanding, may not enable hearers to recognise whatever the description intendedly depict etc. (Drew, 1978: 8).

According to Sacks, the categories can be related to each other, for example as standardised relational pairs (SRPs), which can be found in collection R. Collection R implies a set of rights and obligations concerning the activity of giving help (between lay persons). Collection K is composed of professionals and laymen. These are set up as two separate classes. The professional class is constructed by reference to special distributions of knowledge existing about how to deal with some trouble. Accordingly, they have special rights for dealing with some trouble. All those who do not have this occupation are laymen, the undifferentiated occupants of Collection K. These two category collections have particular relevance to analysis of the way the interviewees' set up the descriptions in Chapters Three, Four and Five.

Given SRPs, the absence of the second part of a pair becomes observable, and thus programmatically relevant. Activities can be bound to particular categories of members where they are categories from MCDs, and are known as category bound activities (CBA). As Silverman (1993) comments, many activities are commonsensically associated with certain membership categories. Members use categories in particular ways to demonstrate their social identities. Therefore, by analysing members production and use of categories and activities, we can see what their social identity is likely to be. Members generate categories, which are used to locally construct descriptions.

Although MCDA is the primary method of data analysis, I have also applied CA to part of the data. MCDA requires some explanation prior to the presentation of data analysis so it has been described in some detail above. I give only a brief review of CA below, as it is best understood when applied directly to the data. The form it takes and its relevance to this data analysis will therefore become apparent in Chapters Six and Seven.

1.5.2 Conversation analysis

Whereas MCDA examines the categorisation work that members do, attention in conversation analysis (CA) is on the sequential features of interaction, in particular on the positioning of utterances in relation to each other. CA is the study of conversation, or 'talk-in-interaction' (Schegloff, 1992a: 104). It focuses on:

> ... issues of meaning and context in interaction. It does so by linking both meaning and context to the idea of sequence. In fact, CA embodies a theory which argues that sequences of actions are a major part of what we mean by context, that the meaning of an action is heavily shaped by the sequence of previous actions from which it emerges, and that social context is a dynamically created thing that is expressed in and through the sequential organisation of interaction. (Heritage, 1995: 162)

Heritage (1997) comments that conversation analytic studies of the social practices that make up the interaction order describe how people take turns at talk in ordinary conversation. This includes how overlaps and interruptions are negotiated, and how basic action sequences are organised and options activated within them.

1.5.3 Applying ethnomethodology to the analysis of social institutions

Some ethnomethodologists are reluctant to engage with policy and practice audiences, because this might mean removing themselves from their position of ethnomethodological indifference (Mazeland and ten Have, 1998; Hester and Francis, 2000). This has contributed to the mistaken impression that ethnomethodological research is data driven (Billig, 1999a) and only produces knowledge about structures, not applications. Such critiques imply that such analysis cannot say useful things about sociological institutions such as health, the family, education and power. There is however, a strong tradition of applied or 'institutional' ethnomethodological research, particularly CA studies on consultations between health practitioners and patients (for example, see Heritage and Sefi, 1992; Silverman, 1997; Peräklya, 1998; Maynard, 1991; Heritage et al., 2001). There is also a smaller, but growing, body of applied MCDA research (for example, see Paoletti, 2001; Griffiths, 2001; Waller, 1996)[24].

[24] Some MCDA researchers have argued against what they refer to as 'the institutional talk programme' of CA. Hester and Francis (2000) argue that such studies fall prey to Schegloff's (1992a) criterion of

Heritage (1997) makes a distinction between social and institutional orders in interaction, which has led to two kinds of CA research. The first investigates the social institution of interaction as an entity in its own right. The second investigates 'the management of social institutions in interaction' (p162). So, as well as the social order in interaction that is studied through ordinary conversation, conversation analysts have investigated institutional talk to see how institutional realities are evoked, manipulated and at times transformed in interaction.

A key assumption of CA is that ordinary conversation is a fundamental domain for analysis and that the analysis of ordinary conversation is a basic resource for extending CA into other 'non-conversational' areas (Heritage, 1995). Research in different areas has shown that communicative conduct in more specialized social institutions embodies 'task - or role oriented specializations and particularizations that generally involve a narrowing of the range of conduct that is generically found in ordinary conversation' (Heritage, 1995: 395). One way in which the institutional nature of interaction may manifest itself is in a range of differences from ordinary conversation:

> The study of institutional dialogue.... focuses on the ways in which conduct is shaped or constrained by the participants' orientations to social institutions... Analysing institutional dialogue involves investigating how their orientation to and engagement in their institutional roles and identities is manifest in the details of participants' language, and their use of language to pursue institutional goals. (Drew and Sorjonen, 1997: 94).

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relevance. In privileging the analysis of sequential matters, the categorical identity work of participants in talk is taken for granted. Whereas I do have some sympathy for this viewpoint, I do not consider this to create the 'significant gulf' between ethnomethodological and applied CA (i.e. the insitutional talk programme) that Hester and Francis suggest. There is often attention to categorical work, though this may not be labelled MCDA. This study applies both methodologies to the data and as such addresses Watson's (2000) point:

> The real 'promiscuity' issue concerning membership categorization turns on whether categorical activities figure in diffuse and unexplicated ways in current conversation analytic and institutional talk program work on local sequential ordering and whether categorization practices can be shown to locally operate as part of members' communicative competence with reference to given instances (p385).

CA works with a dynamic concept of social context. Events or actions in talk are constitutive of context. As Heritage (1995) comments, 'CA starts with the view that 'context' is both a project and a product of the participant's actions' (p163). Events or actions in talk are simultaneously 'context-shaped' and 'context-renewing' (Heritage, 1984: 242)[25]. The relevance and procedural consequentiality of the institutional context and its associated roles, tasks and identities must be shown to inhabit the details of the participants' conduct (Schegloff, 1992a). This is a methodological concern regarding the analysis of institutional interaction (Heritage, 1995: 407), which is compatible with the empirical study of talk through CA and MCDA[26].

1.5.4 Ethnomethodological analysis of interview data

The study of interviews in the broad sense of the term, has been a key concern of ethnomethodologists over the last 20 years or so. For example, there is now a large body of CA research on consultations between doctors and patients (Heritage and Stivers, 1999; Jones, 2001; Maynard, 1991; Peraklya, 1998; Frankel, 2001). Other CA research on interviews includes consultations between non-medical health professionals and patients or clients (Silverman, 1997; Peraklya, 1995; Heritage and Sefi, 1992), and news interviews (Heritage and Greatbatch, 1991; Clayman, 1992). However, consideration of the research interview as a topic for ethnomethodological study, as a social institution in its own right, has been relatively sporadic until recently.

Early ethnomethodological critiques of interview research by Cicourel (1964) and Silverman (1973) highlighted the importance of recognising the way in which interview accounts are collaboratively produced. However, such critiques also appear to have led to an avoidance of research interviews in general by ethnomethodologists. Baker's (1984) study of adolescent-adult interview talk, and Baruch's (1981; 1982) study of interviews with parents of children with congenital conditions, are notable exceptions. Both studies apply MCDA to interview data.

[25] Also see Sacks, Schegloff and Jefferson, 1974.

Baker (1984) observed how interview participants worked to construct a version of adolescent-adult relations for each other in their talk. She demonstrates how both the interviewer and interviewee rely on their commonsense knowledge of social structures in order to produce utterances that are locally adequate. Baruch (1981; 1982) attends to the locally situated nature of the interview data, identifying the way in which interviewees work to construct their identities as 'morally adequate' parents (p28). His analysis is a sociological description of the moral order in the interview data. Baruch's study of research interviews has provided an important context for my study and will be discussed in more detail in Chapter Two and Chapter Eight.

Although ethnomethodologists rarely choose to study interviews as a first resort (Baker, 2002), an increasing number of studies have applied ethnomethodology to qualitative research interview data in recent years (see Hester and Francis, 1994; Paoletti, 2001; Rapley, 2001a, 2001b; Mazeland and ten Have, 1998; Roulston, 2000)[27]. The analysis of the social organization of talk between the interviewer and interviewee can generate insights into matters such as the production of situated identities and the moral work of accounting (Baker, 2002). Baker demonstrates how interviews can be examined in terms of the accounting activities, membership categorization work, and identity work carried out by participants. She suggests that accounting 'is more than reporting or responding; it is a way of arranging versions of how things are or could be' (p781) and is a central feature of interview talk. Further, the accounting, categorisation and identity work that participants do in producing the interview leads to two questions: 'what kind of social world are the speakers making happen in their talk' and 'what kind of social world must speakers assume such that they speak in this way' (p793). Considered in this way interviews can provide a source of data that can be analysed in terms of their construction and provide insights into the social world of which participants are a part.

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[26] This brief discussion of the analysis of institutional talk has primarily referred to CA. However, it is argued here that MCDA studies can also make a significant contribution to the study of institutional talk.
[27] For recent ethnomethodological studies of survey research see Houtkoop-Steenstra (2000), and Maynard and Schaeffer (2000).

Ethnomethodological studies of qualitative research interviews have in general involved applications of MCDA (Hester and Francis, 1994; Paoletti, 2001; Baruch, 1981; 1982; Baker, 1984). These studies have paid particular attention to the construction of identities through members' categorisation work in interview accounts. Recent studies have begun to attend to the sequential structure of interview talk, applying CA to qualitative interview data (for example, see Mazeland and ten Have, 1998; Rapley, 2001b). Rapley's analysis is a significant contribution to what is known about how the qualitative interview 'comes off' (2001b: 2).

Rapley (2001b) carried out a study of qualitative interviews with teenagers about drug use, applying both MCDA and CA. His study examines the tension inherent in interviews of managing the need to collect data on a pre-defined topic that has been externally set up, and the local interactional nature of the interview. Rapley's focus is on the interactions between interviewer and interviewee. However, his detailed analysis of the hitherto under-researched role of the interviewer in the production of qualitative interview data is particularly insightful. He shows how interviewers orientate to a range of competing contexts, doing considerable work to produce themselves as both 'neutral' and 'facilitative' qualitative interviewers. Rapley's analysis emphasises the need for analysts to be aware of how interview talk is locally produced in a particular context. This has implications for how responses to questions, i.e. the interview data, are to be understood.

Analysis of how the interview talk is constructed allows the researcher to identify and examine the practices participants use and the issues they make relevant in their talk. What is talked about is considered in terms of how meanings are set up locally in the interview. The data analysis presented in Chapters Three to Seven demonstrates how this is done by participants in the interviews I have examined. The contribution this makes to what is already known about the status of qualitative interview data, and the implications for the conduct and use of interview research, are discussed in Chapters Eight and Nine.

The interviews analysed here are treated as 'situated' accounts of health care experience. The analysis has concentrated on describing in detail the categorisation and sequential work carried out by the interview participants, using MCDA and CA respectively. Applying these two approaches has produced complementary analyses, culminating in a study that addresses two related sociological issues:

- The status of qualitative research interview accounts
- The status of the interview data as assessments of health care experience

1.6 Assessing health care

This research study set out to contribute to a body of institutional knowledge, the sociology of health and illness. The examination of how the interviews are produced has highlighted a number of analytic points regarding the status attributed to the accounts by the interviewees. They are set up as 'assessments of health care experience'. Setting up the accounts to be heard in this way has implications for the sociology of health and illness, and health care policy, in particular regarding how 'lay' or 'consumer' evaluations of health care experience are produced.

The increasing emphasis on the consumer in government policy (Department of Health, 2001; Crouch, 2000) has led to a search for the best ways to find out about both what consumers want from health services, and how satisfied they are with the services they receive[28]. A great deal of this research is quantitative, but there are frustrations with consumer satisfaction questionnaires and scales, as they tend to show uniformly high levels of satisfaction (Avis et al., 1997). There has consequently been a search for

[28] For example, the majority of the projects recently commissioned by the Department of Health as part of its 'Health in Partnership' research initiative are qualitative (www.doh.gov.uk/). The aim of the initiative is to develop knowledge of how patients, carers and lay people can be involved in health care decision making at different levels, from the Primary Care Trust Board to the doctor-patient consultation.

different ways of evaluating satisfaction with health care, and an increase in qualitative research. It has been suggested that increased interest in qualitative research has in part been fuelled by the growing demand for research that gives consumers a voice in developing services (Boulton and Fitzpatrick, 1994). My study takes up the issues raised above through an ethnomethodological analysis of data initially collected as a form of lay or consumer evaluation[29].

Jayyusi (1991) has highlighted how ethnomethodology, in particular the work of Sacks, provides an analytic method which enables us to consider the relationship between 'statements of 'is' (factual premisses) to statements of 'ought' (evaluative conclusions)' (p232). This means that when we consider the practices in which moral concepts come to life, we can see that description and appraisal are deeply intertwined. We can do this by looking at the practices of ordinary persons, and the actual ways and contexts in which they make moral judgements or decisions. Following Louch (1966), Jayyusi further argues that the investigation of action needs to be sensitive to appraisal as a constitutive feature of that action. Through the local construction of moral order in the interview accounts, participants demonstrably work to produce assessments of health care experience. This is further described by Drew:

> Insofar as descriptions are unavoidably incomplete and selective, they are designed for specific and local interactional purposes. Hence they may, always and irretrievably, be understood as doing moral work – as providing a basis for evaluating the "rightness" or "wrongness" of whatever is being reported. Additionally, our accounts may themselves be evaluated in those terms, that is, in terms of the propriety or fairness or justice or accuracy with which we have reported some (external) events, or our motives in doing so. (1998: 295-296)

The analysis undertaken for this thesis demonstrates the way in which assessments of health care experience are produced collaboratively by the interview participants. It did

[29] The Seale and Kelly study, from which the data analysed in the thesis was collected, was an evaluation of hospice and hospice care for people who had died from cancer and their spouses. We did not refer to the interviewees as consumers in that study. However, since it was carried out the term has become common in the policy and research literature on health care.

not set out to investigate the way in which assessments are carried out in qualitative interview studies. However, it has become apparent throughout the course of the analysis, that the interview participants do considerable assessment work in producing the accounts of the death of a spouse. This has implications for qualitative research in general (see Chapter Eight), and for the lay evaluation of health care experience (see Chapter Nine).

1.7 Aims and objectives of the thesis

Given the focus on interaction, many potential directions for analysis were available at different stages. This has led to making decisions at the start of each new piece of analysis as to what area to examine. The research process will be described in the next chapter.

This thesis has two main aims. The first is to investigate the moral order in qualitative interview accounts describing the death of a spouse. The second aim is to examine the status of qualitative interview accounts.

Analytic objectives were identified over the course of the research and are summarised below:

1. Building upon Baruch's study, to explore the moral work that interviewees do in producing their stories. Specifically:

    a) How they produce themselves as 'reasonable' in the interview accounts;
    b) How the interviewees 'do criticism' of health professionals (and/or query the actions of health professionals);
    c) How participants use assessments in their talk to do 'praise' and 'criticism'.

2. To examine how participants set up and orient to the talk as 'the interview'.

3. Additionally, to consider the implications of the analysis for:

    a) qualitative research (regarding the use of interview data);
    b) the sociology of health and illness (regarding the assessment of health care experience); and
    c) policy (regarding the evaluation of health care experience).

Many qualitative research studies set out clear aims and objectives at the start of a project. These may often refer to collecting and analysing data on a particular topic, such as describing the views of patients about a particular type of illness experience[30]. The aims of ethnomethodological studies such as this one tend to be quite general, centring on the examination of some data. When analysis starts this form of analysis throws up a whole range of possible research problems that could be examined in detail. Decisions therefore need to be made about objectives for particular pieces of analysis at each stage. This process is described in the following chapter in relation to this study. Eventual objectives can be quite specific, e.g. focusing on one aspect of the talk such as assessment work, but this will follow a more general exploratory analysis to see what members are doing in the talk under examination. Objectives therefore tend to evolve over the course of the research, eventually becoming quite specific.

The importance of being flexible about objectives is demonstrated in the way in which the specific topics of 'cancer' and 'bereavement' are not treated as central concerns by the interviewees. I had initially used these labels in early descriptions of the study, and in presentations. However, although these accounts are about cancer, in that the 'story of the death' requested is about cancer, the interviewees do not topicalise cancer. In a similar way, as a researcher I had been referring to the data as 'accounts of bereaved spouses' giving the impression to myself and others, that the analysis is about bereavement. However, the interviewees do not make bereavement relevant to their

[30] This will usually be a requirement with funded research.

descriptions, i.e. they do not talk about their personal experience of being bereaved[31]. This supports the need to consider the relevance of the local context in the production of meanings:

> The presumption is that the selections and descriptions used are relevant to the point of the story, or the action, which is constituted by any local utterance/discourse, relevant that is to the task at hand, and also relevant for the *hearer's understanding* of the discourse and task at hand. (Jayyusi, 1991: p238)

1.8 Structure of the thesis

The thesis consists of four main sections. Part One includes two chapters, a general introduction (this chapter), and a natural history of the research. Part Two includes three data analysis chapters where MCDA is applied to the interview data, primarily focusing on the interviewees' accounts of their experiences. Part Three includes two data analysis chapters where CA has been applied to the interview openings in order to consider the local production of interviews.

The last section, Part Four, contains two chapters that discuss the implications of the analysis for a number of different audiences. Chapter Eight reviews how the present analysis takes forward Baruch's research, and discusses methodological implications for qualitative interview analysis. Chapter Nine considers how the analysis contributes to the sociology of health and illness, and health care policy and practice. A final short chapter (Chapter Ten) describes the limitations of the research and offers some recommendations for further research.

[31] Hansberry's (1988) comment on her play *A Raisin in the Sun* is included as a postscript on page 286 and offers an interesting interpretation of the significance of attending to the local detail of members' talk.

CHAPTER TWO

A NATURAL HISTORY OF THE RESEARCH

2.1 Introduction

This chapter will describe the process through which the research has developed. It is presented as a natural history of the research. It is in place of, but does not *take* the place of, the more conventional literature review and methods chapters, which would traditionally be included at this point. My intention is to 'nest' the research problem (Wolcott, 1990: 17) in the two introductory chapters (Chapters One and Two).

2.1.1 Reviewing the literature

Analysis of members' concerns has led to the development of three different but related pieces of analysis on criticism of health professionals, assessment work in interviews and the construction of the talk as the interview. The overall analysis contributes to two main areas: the status of qualitative interview accounts, and lay assessments of health care experience. A number of different literatures have been reviewed and drawn upon at different stages of the research. The ethnomethodological nature of this study means that a formal literature review carried out at the beginning of the research would have stifled the creative use of the literature in developing the analysis (Frankel, 1999). In addition, a formal literature review positioned at the start of the thesis would present a problem of coherence for the reader given that several literatures would need to be presented if this approach were taken. These considerations have led to an alternative approach to reviewing and presenting the literature here.

My purpose is to document the relationship between myself as reader (of the research literature), the text(s), and the data. Meaning does not lie inert in the literature but depends upon a relationship between the reader and the text. Texts should be referred to so that the analyst's voice emerges in such a way that it is contextualised and honest (Andrzejewska, 2002). The literature is included here as part of a dialogic process rather than a review of a particular issue placed at the start (Silverman, 2000). This approach follows Silverman's (2001) suggestion that readers of research should trust the tale and

not the teller. Thus I suggest it would not be useful to the reader, or appropriate, to set up a particular reading of my analysis before presenting it[32].

My data analysis raises and addresses a number of analytic problems. The emergence of these issues through the data analysis is considered in relation to how the study contributes to what is already known. Literature has been read and critiqued throughout the research, with a focus on defining my research problem (Silverman, 2000). However, my intention has been to use the literature selectively and appropriately, with the literature being brought in where it is needed in the text of the thesis (Wolcott, 1990; Silverman, 2000). This will be done by considering the connection of the analysis to the key literatures that have become relevant during the course of the research. In Chapters Eight and Nine several readings are drawn for the different audiences for whom the research has implications. These audiences are: qualitative researchers, sociologists of health and illness, and policy makers.

2.1.2 Organisation of this chapter

This chapter will describe the research process, starting with some background as to how decisions were made about the research problem and methods. This includes an introduction to Baruch's analysis of interview data, and a description of some early analysis of my interview data. This preliminary data analysis demonstrated some of the moral work that interviewees do in producing their interview accounts, and showed how the interviewees work to do 'being reasonable' in their accounts. I then document the way the research evolved through the three main analytic phases:

1. Setting up criticisms of health professionals in interview accounts.
2. The production and use of assessments in research interviews.
3. Doing interview talk.

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[32] I am not arguing that formal literature reviews are not appropriate in all research. It depends upon the research design and models used. The analysis is central to the reporting of any empirical study. The literature needs to be presented in the way that best allows the reader to assess the quality of the analysis.

2.2 Beginnings

The research process began when I took up post as Research Associate on the study of hospice and hospital care of people with terminal cancer which was described in Chapter One. The aim of that project was to compare the quality of the care between the two types of institution. I had worked as a research nurse at St. Christopher's Hospice (who funded the project) for four years before starting this project. I had also just completed a part-time MA in Sociology and Qualitative Research at Goldsmiths College. I wanted both to use some of the data from the project for a PhD and to do ethnomethodology.

My interest in ethnomethodology arose during the course of my MA. I was drawn to the way it made it possible to identify the skills and practices ordinary people use to produce social action. The micro-analysis of social interaction seemed to me to be a valuable way of understanding some of the health issues and problems I had encountered in my experience working in clinical health settings as a psychiatric nurse and as a research nurse. Many of these problems appeared to hinge on the interactive practices and skills of the various parties involved (professional and lay people).

In my post as hospice research nurse I worked on a range of different topics. In one study I recruited breathless patients to a randomised controlled trial. It was this that got me interested in the (mis-matched) relationship between methods of measurement used in research and the actual practices of the people being researched. Regarding this research trial, breathlessness was said to be a subjective symptom and measured accordingly in research studies[33]. However, in practice I found that nurses and doctors produced their own assessments of the patient's breathlessness, which sometimes did not correspond, either with each other or with the subjective assessment of the patient themselves[34]. This problem formed the basis for my MA dissertation in which I applied

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[33] There is no reliable way of objectively measuring symptoms such as breathlessness. For example, physiological measures such as lung function do not correlate with how breathless a patient may feel. Therefore in treating the symptom, the only person who can measure it is the patient.

[34] The problem is not that the doctors and nurses are making assessments of how breathless patients are and treating them accordingly, but that this assessment work is not recognised in research studies such as drug trials that evaluate the efficacy of such treatments. This indicates that the drug trials may be based on one type of practice, and actual treatment decisions on another.

Goffman's frame analysis (1986) to patient case note data (Kelly, 1994). This study highlighted the importance of looking at *how* people do things, rather than what they say they do. However, it only went so far in examining members' practices[35].

2.2.2 Choosing ethnomethodology

The experience of doing my MA research, together with my experience as a practitioner, policy maker[36] and sociologist, led me to believe that social research driven by theoretical concerns (rather than by a defined social problem) can contribute to policy and practice. It can do this through developing knowledge about social issues such as experience of health care but without setting up a rigid definition of the problem at the beginning. This ties in with my experience as a health researcher and practitioner up to that point, where I had observed that problems often appeared to arise around attempts to measure states of health and disease through imposing particular definitions and categorisations. There seemed to me to be value in taking a step back to get a closer look at the phenomenon in order to move forward. More useful outcomes may be achieved if theoretical imperatives drive the research in a direction which can offer new perspectives on social problems (Silverman, 1998b). Theoretical concerns should steer the analytic conception of the research problem otherwise there is a danger of taking the research problem at face value, and of providing policy makers and practitioners with the answers they require, in *their* terms.

This raises the important issue for social scientists, policy makers and practitioners, of how best to utilise findings from academic research in developing social policy and practice, and ties in closely with decisions on research funding. This will be discussed further in Chapters Eight and Nine.

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[35] Goffman is recognised as a significant figure in the development of ethnomethodology. He established that social interaction is a form of social organization in its own right and forms the 'interaction order' (Heritage, 2001). However, ethnomethodology diverges from Goffman's work in its focus on the recognisability of action. Goffman's interest is in the moral order underlying interaction, whereas ethnomethodology is interested in how the 'interaction order' is locally constructed and recognised (cf Heritage, 1995).

[36] I have previously worked at the Health Education Authority as a research manager. My main role was to develop, commission, and manage research projects to support public health/health promotion policy.

My goal was to allow theoretical imperatives to guide the research. This meant I wished to be true to the principles of ethnomethodology developed by Garfinkel and Sacks, yet at the same time undertake a study that would contribute new perspectives to the sociology of health and illness.

As mentioned in Chapter One, it was agreed I would begin the interviews with a similar form of request to that used by Baruch, 'could you tell me the story of what happened'. These stories would constitute my data. I present a brief overview of Baruch's study here in order to introduce my own analysis and to begin to demonstrate how my analysis diverges. A detailed critique of Baruch's analysis in relation to my data analysis is offered in Chapter Eight.

2.3 Baruch and 'moral tales'

Theory influences the way research studies are conceived, both in terms of the disciplinary approach chosen and in the choice of analytic method. The issue of interest to the researcher, and the body of knowledge already available on it, will also have an influence on the study. Ethnomethodological research is generally divided into two types, mundane or everyday talk (Pollner, 1987), and institutional talk (Heritage, 1997). This means that the area of interest will also have an influence on the data chosen, the methods used, and the audience(s) at which the finished work is aimed. For example, CA studies of doctor-patient consultations are undertaken with the aim of contributing to knowledge about communication in clinical settings. My interest is in doing research that can broadly speaking be said to contribute to the sociology of health and illness. Baruch's study of qualitative interview data provided a valuable starting point for my analysis[37]. He had adopted an ethnomethodological approach to the data as I intended to, and had studied interviews with people caring for a family member about their experiences of 'health and illness'.

[37] I refer in this thesis primarily to Baruch's (1982) PhD thesis. His 1981 paper is based on his PhD analysis.

Baruch analysed 27 interviews conducted with parents of children born with congenital conditions. He set out his thesis as a sociological study of parents' responses to such problems in their children. His analysis builds on earlier studies by Voysey (1975) and Locker (1981), which also examined interviews with parents of children with medical problems. Voysey and Locker demonstrate that interviewees work to produce themselves as 'morally adequate' in their interview accounts. However, whilst Baruch recognises the importance of this contribution, he identifies two methodological weaknesses in their research. Firstly, they do not show how the status of moral adequacy is displayed by parents in the construction of their accounts. Secondly, they do not demonstrate the 'normative character of respondents' statements' (1982: 43). This opens their work up to the potential charge that they have selected data to fit their theoretical propositions.

Baruch sets out to address these issues in his analysis, through treating parents' talk as 'situated account(s) aimed at displaying the status of morally adequate parenthood' (1982: 28). His central aim is to show 'how parents display the status of moral adequacy by presenting determinate alternative possible accounts when considering unit troubles or problems' (1982: 39). I was interested in building on Baruch's analysis in terms of both his analytic approach to the data and of his explication of the moral work that interviewees undertake in their accounts.

Baruch initially undertook what he refers to as a 'crude' quantitative analysis of his data using MCDA (1982: 2). His application of MCDA involved explication of all the 'pairs of actions or states of affairs described' (1982: 45) by interviewees. He also identified the 'norm which sequentially related one action or state of affairs to the other' (1982: 45). In this way he uses the whole of the data set available, which enables the relative distribution of categories to be seen. The analysis of categories and norms is followed by qualitative analysis of the way in which parents produce themselves as morally adequate.

Baruch develops his research problem from weaknesses identified in earlier research. My approach differs in that I began with a much broader aim, to investigate the moral order in qualitative interview accounts describing the death of a spouse. The stance taken was one of ethnomethodological indifference to the data. In line with this, I did not set out to specifically address weaknesses in Baruch's study, but to take his analysis as a starting point and develop a more detailed analysis of qualitative interview data. The way in which I have carried out MCDA differs from Baruch's quantitative application, and has involved intensive analysis of a number of data extracts drawn from five interview accounts (see Chapters Three, Four and Five). I have also undertaken analysis of how the talk is produced as situated interview talk (see Chapters Six and Seven). The process of analysis undertaken here has enabled me to identify a number of limitations in Baruch's study and the claims made for the analysis. These are examined in detail in Chapter Eight[38].

2.4 Developing my research problem

Following Baruch, I was interested in how interview participants construct and attend to moral issues in their talk. The relevance of the moral order for sociologists is central as it consists of 'the rule governed activities of everyday life' (Garfinkel, 1972: 1). Bergmann (1998) identifies two ways in which morality emerges in discourse. The first is the 'principles and forms through which moral issues are handled in social interaction' (p279). The second is the way in which moral implications and the consequences of particular verbal activities are topicalised:

> Whereas the first perspective takes morality as its starting point and asks how it is interactionally accomplished and shaped, the second perspective starts from interaction and pursues how moral concerns become relevant in and through the social organization of interaction. (1998: 279)

Heritage and Lindstrom refer to these perspectives as 'the moral order *of* interaction' and 'the moral order *in* interaction' (1998: 397). Central to the moral concerns of participants is the construction of identities in the talk, and the associated roles and

[38] Baruch's study is of course now 20 years old, and I have also benefited from a range of empirical and theoretical resources unavailable at that time.

responsibilities. As Goffman (1955, cf Heritage and Lindstrom, 1998) observed, the interaction order is both a social institution, and a moral order made up of institutionalised rights and obligations. The focus here is on the moral order *in* the interview talk.

My interest was in undertaking research that would contribute to the sociology of health and illness, and health policy and practice. The data were therefore considered as a place in which health and illness exist[39]. At the same time I have tried not to make assumptions as to what form health and illness might take in the data. Attention is given to members' practices and the issues that are made relevant by participants. It means that context is considered a members' issue, rather than being externally imposed (Heritage, 1984). This differs from Baruch's analysis, which from the start was more firmly grounded in theoretical concerns developed by Voysey and Locker in relation to accounts of parents of sick children. He aimed to identify members' practices in relation to particular issues (moral status of accounts).

Sacks demonstrated the analytical value of looking at the apparatus or machinery that has generated the observations of the speaker(s) (1963; 1984). The research problem for the sociologist is not the observations themselves, but the explication of the apparatus through which they are constructed. This is also described by Schegloff (1992a):

> A solution must be found to the analytic problems which obstruct the conversion of intuition, casual (however well-informed) observation, or theoretically motivated observation into demonstrable analysis. For without solutions to these problems, we are left with "a *sense* of how the world works," but without its detailed explication. (p106)

My initial intention was to explore the character of the moral accounting work members do and the way it is constituted in these interviews. The interviews have been treated as naturally occurring talk. The emphasis in the first instance is on investigating *how* the interviewees (surviving spouses) are saying what they say (as members of a social

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[39] This issue will be taken up again in Chapter Nine.

world), rather than focusing on *what* they are saying, such as 'bereavement talk'. In other words this is a study not of bereaved spouses, but of social interaction. It addresses the analytic points suggested by Baker (2002) regarding interview data, about what kind of social world the speakers make happen in their talk and what kind of social world speakers assume so that they speak in this way (see Chapter One).

2.5 Getting into the data: doing being reasonable

I began the analysis by reading and rereading the five interview accounts I had initially transcribed, looking for a starting point for my analysis. At this point my main interest was in the talk of the interviewees, partly because they did most of the talking. I followed Sacks's call to examine some (interview) data in terms of 'how it is that the thing comes off' (1992; LC1: 11) but as so much goes on in talk, a decision needed to made as to what the 'thing' would be. Several interesting issues regarding the activities interviewees were doing in their accounts arose which appeared to warrant further exploration. These included: producing a 'reasonable' account, the use of time to locate events, the constitution of lay and medical competences, criticism, gender, and emotion.

Given that there were several possible directions for the data analysis, a decision had to be made about what to look at first. In line with the (ethnomethodological) principle adopted by Baruch, that a feature of all accounts is a display of moral adequacy, a key characteristic of these accounts seemed to be the way in which the interviewees construct their behaviour and that of others as reasonable or unreasonable in their descriptions. This seemed like a productive place to start. I again read and reread all the transcripts, this time extracting sections in which the spouses appeared to be presenting their behaviour and that of others as reasonable or unreasonable, systematically analysing the extracts using MCDA. This involved systematically going through the data extracts identifying standardised relational pairs (SRPs), e.g. husband and wife, and other categories, as well as looking for the use of devices such as category-bound

activities. The analysis of how the interviewees do 'being reasonable' was preliminary to the main analysis described in Chapters Three to Seven.

The way in which members achieve an account in which they can be heard to be reasonable will be illustrated in relation to the extract below. Transcription notation is described in Appendix 3 (page 321), which also includes a note on how the data extracts are presented in the text of the thesis.

Extract 2.1 (Interview 4)

IR's question was not recorded and is therefore not included here.

1 IE Well (0.1) its about this time last year (0.2) erm my husband felt he had flu coming on (.)

2 IR Yes (0.2)

3 IE and (.) obviously it didn't seem to clear up (.) so nagging wife says get to the doctor

The interviewee sets up an MCD with the SRP husband-wife ('my husband'). A rule is set up that if an illness persists and the husband does not seek medical help himself, his wife will take responsibility for deciding he should seek help. The interviewee here categorises herself as a `nagging wife' directly. Nagging is a word that goes with wife. It is bound to the category wife by the interviewee. In giving no explanation as to what she means by 'nagging', she infers that the meaning of the nagging wife is commonly understood. However, her motive in nagging is locally constructed.

She relates 'nagging wife' to her husband's symptoms not clearing up through the use of 'so'. She also binds it to the activity of getting someone to do something, in this case nagging someone to seek medical advice. Two potential versions of nagging are available to the hearer, unreasonable or reasonable behaviour (of a wife). A commonsense version of nagging is that it is irritating, as in nagging toothache. The interviewee does describe herself as nagging in the sense of being irritating, but constructs it as reasonable behaviour, through binding her behaviour to her husband's enduring flu symptoms. So, in this extract, the motive behind nagging is constituted as something good, as appropriate behaviour of a wife whose husband is ill and does not seem to be getting better. The nagging is therefore situated as a 'pre-emptive strike'

(Cuff, 1980) against the potential charge that she is interfering and thus being unreasonable. The way it is used to pre-empt a criticism is similar to the use of the term 'neurotic mother' by the mother of a sixteen year old patient in Silverman's (1987) data:

Extact 2.2: Silverman (1987: p244 - NT: 19.2)

1 HV: Could you have a word with Mrs A please?
2 M: [*enters*] The neurotic mother heh heh
3 HV: [*softly*] No, no

The mother in the extract above has turned up in the consulting room on her own despite a request from her child that she be excluded. Silverman describes how the term 'neurotic mother' is used to account for the breach in the mother-child SRP as the child is at an age where the mother is not expected to see the doctor independently of her child.

The interviewee in Extract 2.1 emphasises the reasonableness of her behaviour through showing that she did not nag her husband to go to the doctor straight away, only when the flu symptoms did not go away. This also gives him some time to make the decision himself, which he apparently did not. This is important as nagging could also be heard as getting someone to do something against their will. She is heard to do this here, but we can see that in this case going against someone's free will is the best choice of two possible options, to let her husband carry on with persistent flu symptoms, or to persuade him to go to the doctor. If she had not intervened and had let her husband's symptoms persist ad infinitum, her behaviour would be seen as uncaring and thus unreasonable behaviour of a wife.

An MCD is also set up in which interviewee-interviewer are an SRP. The outcome of the persistent illness is referred to and bound to the category death, though this is inferred rather than formally stated, by using 'obviously'. The interviewee uses 'obviously' to bind the persistence of the illness to the fact that the hearer already knows that her husband dies. This is an appeal to what Schutz (1970) calls intersubjectivity. Here both participants are taken to know that the persistent illness described at the

beginning of the story in the extract above and the eventual outcome of death are related. It is a demonstration of the recipient-designed nature of the account. This works to constitute the behaviour of the interviewee as reasonable. The flu symptoms are bound to her husband's eventual death.

This analysis of membership categorisation work by interviewees enabled me to begin to systematically analyse how the interviewees produced accounts that could be heard by the interviewer as 'reasonable'. To do this they constituted their own actions in the events described as reasonable (in the sense that they are fair, unbiased, etc.). It would otherwise be possible that the hearer would not be convinced that the account was a plausible description of events. This is in line with Sacks's suggestion, that people attend to the business of being ordinary or unremarkable, presenting reports of apparently unusual experiences in a way that makes them sound unexceptional.

> A kind of remarkable thing is how, in ordinary conversation, people in reporting on some event, report what we might see to be, not what happened, but the ordinariness of what happened. (1984: 414)

Here the interviewee presents their behaviour as unexceptional, or what any reasonable person would do given the circumstances. They do this through generating categories and constructing rules of use that contribute to the production of a moral tale (as with Baruch's parents of children with medical problems). Members are at pains to demonstrate that their account is socially situated, locally constructing norms to create ordered descriptions of events. The listener is convinced of the reason of the speaker's account through the demonstrably rule governed (moral) nature of what is described. This is shown in a number of ways in the data extract above, and in the analysis chapters that follow.

At this point I had begun to identify in my data, as Baruch had in his, the way in which interviewees (as members of society) use 'background expectancies as a scheme of interpretation' (Garfinkel, 1972: 2). I had started to uncover the moral order in identifying some of the rules which interviewees set up and use in producing their

accounts. The way in which members demonstrate the reason of their actions in their accounts of events has also been shown by Baruch and Voysey. My analysis of 'doing being reasonable' therefore took me to the level of what is already known by sociologists, that members of society attend to moral concerns in their actions, as here in their talk.

My intention was to undertake a more detailed analysis of how the interviewees constructed their accounts to be heard as reasonable, to enable me to begin to identify what was going on in the talk, what devices were used and to what ends. This would not be an attempt to corroborate Baruch's findings. Rather I wished to use his work as a springboard into new areas of analysis, as a starting point to build upon rather than an end point. The emphasis is on seeing what issues emerge from the data analysis, rather than on searching for particular patterns, e.g. reading the data as 'bereavement talk'[40]. This has provided a relatively efficient way of developing new knowledge through more detailed analysis.

This preliminary analysis enabled me to identify ways in which moral work was done in these particular interviews[41]. Baruch's analysis had examined the way in which some interviewees described the behaviour of health professionals often in a negative light. Following Stimson and Webb (1975), he referred to such accounts as 'atrocity stories'. In my initial examination of the data I had started to pick up on the way in which criticism featured in the interviewees' accounts. It was also a feature of the moral work done in 'doing being reasonable'. Criticisms were primarily made regarding the actions of the health professionals. However, they were also made regarding the interviewee themselves and the dead spouse. I decided to undertake a more detailed analysis of how criticisms of health professionals are achieved. This forms the first main piece of

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[40] I initially referred to the interviewees as bereaved spouses which of course they are. However, this proved to be misleading as they were not making their experience of bereavement directly relevant in the interview accounts analysed here.

[41] In a sense this is similar to running basic descriptive ('top line') statistics on a survey data set, which enables the analyst to pick up potentially interesting relationships which may be worth pursuing further.

empirical analysis presented in the thesis (see Chapter Three). My goal was to allow theoretical imperatives to drive the research, and to follow the principles of ethnomethodology developed by Garfinkel and Sacks. At the same time it was hoped that it would add to what is known about the sociology of health and illness.

2.6 The research process: criticism, assessments and the interview

I reread the transcriptions of the first five interview accounts, identifying instances where criticism of health professionals were made[42]. The health professionals referred to specifically were doctors and nurses[43]. MDCA was applied to the data. Identification of criticism in the accounts was not generally clear-cut. Considerable identity work was carried out around criticisms. This can be seen in the data analysis, where a number of different 'types' of criticism have been distinguished, ranging from 'very cautious' to 'direct'. Ambiguity is used by the account-giver, with the recipient being drawn into the production of the description as criticism. Even when the interviewee identifies their action as criticism, considerable moral work goes on regarding the roles and responsibilities of those involved, including the interviewee and interviewer.

I had initially intended to undertake separate analyses of instances of criticisms of self (by the interviewee) and of the dead spouse in the accounts also. However, having undertaken the analysis of criticism of health professionals, and following the ethnomethodological principles I had adopted, I decided a more constructive tack would be to conduct a closer analysis of members' practices in producing the accounts. As mentioned earlier in this chapter, it would involve taking a step back in order to take a closer look. I had identified criticism as an activity in the talk in a similar way to more traditional qualitative studies, and gone some way to describing how it was produced by interviewees through categorisation work. I now wished to examine in more depth how

[42] I listened to five more tapes to see if there were major differences but decided that there were enough examples of criticism in the first five cases to undertake a detailed analysis for the purposes of this chapter (Chapter Three).

[43] Often there was not a distinction between these two groups, and the health care organization would be referred to as 'they' or by name. Particular groups were not singled out for criticism (or praise). Rather criticism was done in relation to particular scenarios included in the accounts.

activities such as criticism are constructed in the interview talk. This meant refocusing my analysis to look more closely at how the interview accounts are produced as 'stories'.

Drawing on Sacks's (1992) analysis of storytelling, I started again to examine the five interview accounts in terms of their structure. The construction of stories can be examined ethnomethodologically, treating the accounts as situated, either in terms of their sequential structure as a form of talk-in-interaction through looking at turn-taking, or by explicating some of the categorisation devices used in their construction. As the data involved mainly one person speaking[44], it was decided to look in more detail at some of the other (non-sequential) types of devices used in constructing the descriptions as stories. This would enable me to begin to find out how activities in the stories emerge in the way they do, e.g. as instances of criticism or praise.

A research genre has developed around the analysis of stories or narratives[45]. My interest was not in doing narrative analysis in the sense of looking at the overall tale in terms of a central plot (Mattingly, 1994). I was more interested in pursuing the way in which 'socially shared resources of rhetoric and narrative are deployed to generate recognizable, plausible, and culturally well-formed accounts' (Atkinson, 1997: 341). The data extracts in Chapters Three, Four and Five can be regarded as stories in themselves. They form 'small activity systems' (Goodwin and Goodwin, 1992: 181) which have their own plots, yet they also orient to their significance as part of a larger project they are engaged in.

A number of devices were identified in the stories which are used to produce a 'recipient-designed' account (Sacks, Schegloff, and Jefferson, 1974: 727). Devices such as 'course-of-action' and 'economy' are features of story design which demonstrate that:

[44] This has been referred to as 'discourse unit talk' by Mazeland and ten Have (1998) in their analysis of interview data.
[45] For example see Reissman, 1990; Greenhalgh, 1999.

> ...the observed coincidentality of stories turn on that they're designed for an organised economy for some purposes; that that design is unseen by the designer; that the designer however can perfectly well encounter its organised economy and be struck by it. (Sacks, 1992; LC2: 239)

Other devices were identified in the way the accounts are produced, including the use of 'instancing', 'chronology', and 'etcetera clauses'. However, an important feature that tied in with my interest in the moral work people do in their accounts and my earlier analysis of criticism, was the notion of 'assessment work'. Assessment work is central to producing a moral tale. The use of assessments has been examined in a number of CA studies (Pomerantz, 1984; Taylor, 1999; Heritage and Stivers, 1999; Antaki et al., 2000). I have analysed how assessments are used in members' categorisation work. The construction of lay and professional identities were found to be significant resources in producing assessments of the actions of health professionals. The analytic focus in this analysis is how assessment work is done. However, the assessment work carried out in the data extracts analysed involves producing praise and criticism of health professionals. The decision to divide the work into two chapters on assessment work into praise and criticism respectively, has been made on pragmatic grounds. It is not my intention to produce an in-depth analysis of how praise is produced in interview accounts (although the comparison is useful in developing the analysis).

Identity work was a central feature of the analysis to this point. MCDA enabled me to identify how the interviewees use category sets Collection R and Collection K to set up lay and professional identities and related roles and responsibilities. These identities are used as a resource by the interviewees to construct their descriptions of the death of their spouse. Participants also do identity work in order to produce a context for the talk as the interview. As with other institutional talk such as professional-client consultations, participants do not generally refer to the institutional labels 'interviewer' (IR) or 'interviewee' (IE) in their talk. They are my analyst's categories and have been allocated to the participants. Participants construct the identities sequentially, but do not give them categorical labels. The need to explicate rather than assume the identities of IR and IE was driven by an ethnomethodological imperative not to take the identities for

granted[46]. My main motivation was a desire to follow the research principles set out by Garfinkel and Sacks. However, this has not been just a paper exercise.

The most appropriate way of analysing how the identities of interviewer and interviewee were set up was to examine the sequential work through the application of CA to the data. This was done through the analysis of the opening sequences of the interviews. Although my initial motivation for doing this analysis was in a sense to 'tick the box', it has contributed considerably to the interpretation of the data analysis as a whole, and the establishment of its validity. It has particular relevance to the implications that have been drawn for the sociology of health and illness, and policy and practice.

2.7 A brief reflection on the research process

I have worked as a health researcher for a number of years, and this study has been the first time I have not set out with at least a fairly well defined problem that needed a solution. This includes qualitative studies in which the goal may be to describe something about which little is known. Even in such studies, however, you do know what you are required to produce a description of. In this instance I was attempting to describe something that I knew was going on but could not see at the start. The need to refrain from introducing my own categorisations *before* producing the description of members' practices that I was aiming for has not been easy. However, I believe that the fine grained analysis of the practices engaged in by interview participants has enabled me to contribute the new insights to the sociology of health and illness that I had hoped for at the start. What attracted me to ethnomethodology is how, in its suspension of interest in external structural factors, the skills of participants in producing social action through talk are demonstrated. This is made possible through the focus on describing 'actors' viewpoints and definitions as the basis for rational actions, and for their participation in the sites of social life' (Drew, 2001: 267).

[46] The need to analyse the production of these identities in the talk was prompted by having attributed the label bereaved spouse to the interviewee early on in the analysis. I realised that this was not an identity being formally set up in the talk and was misleading. It was necessary to analyse how identities were constructed in the interview by participants.

The main empirical analysis is presented in the following five chapters.

PART TWO: DESCRIBING HEALTH CARE EXPERIENCE

This section examines the way in which the interview accounts, of the death of a spouse, are produced. Overall, the analysis in this section attends to how descriptions:

> ... are themselves accountable phenomena through which we recognizably display an action's (im)propriety, (in)correctness, (un)suitability, (in)appropriateness, (in)justice, (dis)honesty, and so forth. (Drew, 1998: 295)

The way the interviewees account for their actions for their actions and those of others in describing their experiences of health care will be examined. The main focus of analysis is the categorisation work undertaken by the interviewees. However, the analysis also draws more broadly on ethnomethodology, including Sacks' (1992) work on story telling, and the way different resources are used to produce actions such as criticism. Chapter Three examines the work the interviewees do in producing criticisms of health professionals. It forms an empirical basis for a more detailed analysis of how assessment work is carried out in the accounts which follows in chapters Four and Five. Assessment work is carried out by interviewees in describing their experiences of health care, and contributes to the production of the accounts as 'assessments of health care experience'.

CHAPTER THREE

CRITICISING HEALTH CARE PROFESSIONALS

3.1 Introduction

The preliminary data analysis discussed in the previous chapter begins to demonstrate how interviewees account for their actions in their descriptions. They attend to how they present themselves as morally accountable, or reasonable, and in this way they can be seen to orient to how their accounts may be evaluated by others. This is done 'in terms of the propriety or fairness or justice or accuracy' with which they report some (external) events, or their motives in doing so (Drew, 1998: 295-6). This chapter will examine another aspect of description in the interview accounts, that is how the moral work is to be understood 'as providing a basis for evaluating the "rightness" or "wrongness" of whatever is being reported' (Drew, 1998: 295).

A central aspect of the data is describing the actions of self and others critically in relation to particular events that form part of the interview account. Most of the criticisms are regarding the actions of health professionals[47]. The interviewees do not usually identify their actions as criticisms, but they can be heard to be 'doing criticism'. As Drew comments:

> Conduct is not, of course, intrinsically or automatically to be regarded as a violation, a transgression, or as reprehensible: It is constituted as such through reasoning about events and behaviour – that is, through accounts of conduct and thus in a general way through discourse... (1998: 312)

Criticism of health professionals in the interviews takes a number of forms. The way criticism is achieved in these accounts is a finely tuned, locally constructed process, an important part of which is to demonstrate the moral accountability of the interviewee. Descriptions can include accounts of both the behaviour of others and of themselves, but the interviewees take care to avoid attracting criticism to their behaviour when they make criticisms of others. The way in which it is done depends in part upon the type of evidence available to the teller to support it. This includes the relative distribution of lay

[47] They do also criticise themselves and their spouse at times.

and professional roles and responsibilities. This is examined here using MCDA as the main method of analysis.

The overview of MCDA in Chapter One, and the illustration of how it was applied in the preliminary data analysis in Chapter Two demonstrate the way it enables investigation of how interviewees set up and use a number of resources or devices to achieve their criticisms of health professionals. Standardised relational pairs (SRPs) are identifiable pairs that can be seen to have certain standardised rights and obligations, for example, mother and baby, husband and wife, doctor and patient, interviewer and interviewee. Collection R contains pairs of categories with associated obligations of help, e.g. a mother would be expected to attend to her baby if it was crying. Collection K contains pairs of categories involving lay and professional obligations. The use of Collection K enables participants to distinguish between lay and professional roles and responsibilities, and is an important resource in producing criticisms of health care professionals. It helps to define what activity is appropriate to a particular lay or professional role. However, as can be seen in the data analysis, this is not always presented as clear-cut.

The analysis presented in this chapter is based on five interviews[48]. It has been developed from the preliminary analysis of 'doing being reasonable' which was discussed in the previous chapter. Categorisation analysis entails detailed explication of members' work at the point of presentation. The amount of data that can be included is therefore limited[49]. The emphasis also is not on producing a comprehensive analysis of what is going on in the interviews (for example, along the lines of grounded theorising), but in providing a detailed analytic account of particular interactive work that members are doing. The emphasis is therefore on explicating how these descriptions are produced, rather than producing a researcher's account of what they are saying and why. As Silverman and Gubrium argue:

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[48] The first five interviews carried out in the study were selected for analysis in Chapters Three, Four and Five.

[49] The analytic process initially involved identification and analysis of all the instances of criticism in the first five interviews.

> ...one's initial move should be to pay close attention to how participants locally produce or enact contexts for their interaction, in order to reveal the practices by which social order is accomplished.... by beginning with the how question, before or in direct relation to why questions, we can fruitfully move on to broader why questions to "explain" the place in everyday life of structural or cultural constraints, on the one hand, and expectations or identities on the other. (1994: 180)

The importance of this point for research on lay criticism of health care is considered in the final section of this chapter (and in Chapter Nine).

A further instance of criticism is presented in Chapter Five, with the focus on how detailed assessment work is carried out by an interviewee in criticising some health professionals. The data extracts were identified by myself (the analyst), as instances of the interviewees doing criticism, and have been selected on that basis. In all but one of the extracts, the interviewee does not identify their action as a criticism. Criticism is therefore used here as an analyst's category. The importance of identifying activities such as criticism as analyst's categories will become apparent over the course of the thesis.

The analysis is presented as a loosely constructed continuum of criticism, ranging from 'very cautious' to 'direct'. The continuum is used to organise the chapter for the reader in order to demonstrate how caution may be used in doing criticism, rather than producing a typology. In the first extract, the interviewee can be seen to very cautiously criticise the health professionals. The three extracts that follow involve less caution. The last of these extracts is identified by the interviewee as criticism and is discussed as an example of direct criticism.

3.2 Very cautious criticism

The extract below is an example of very cautious criticism. A number of things the speaker refers to here can be taken to be critical of the health professionals, though this

is done cautiously, and constitutes doing the criticism as a delicate matter. It is of note, however, that the interviewee does not constitute everything described in the extract as delicate, or critical, which highlights the need to consider the way in which context is invoked in description (and how meanings are locally constructed).

Extract 3.1 (Interview 3)

IR You know the services you recei:ved and what hap some of it actually you've already told me so I can make a note of it but erm[50]:

1 minute 30 seconds into the taped interview. Story to this point: IE's husband had several courses of antibiotics for what was though to be a painful ingrowing toenail, with no improvement. IE takes him to hospital where he has a local anaesthetic in his toe. Goes back home and sleeps for while but then has to be taken back to hospital where they do 'about 12 tests'.

1 IE I heard a doctor saying to the nurse they didn't discuss it with me but I
2 heard them saying something about the lesion on the lung (0.4) and (0.1)
3 then (0.4) er they said they were going to admit him (.) so they admitted
4 him (.) and then they did this erm on the Monday they the camera
5 for (.) to investigate (0.2) and they found a blockage in the left groin
6 which (0.2) er was to do with the pain in the toe (0.3) and er they
7 the left groin said that they'd do the bypass on the Wednesday (.) in the
8 meantime I mentioned about the lesion on the lung (.) so then they
9 decided to do (.) do a biopsy they had another scan

The interviewee (IE) can be seen to set up three SRPs in this extract: doctor - nurse, health professionals - wife ('me'), health professionals - sick husband ('he'). These are used to distinguish between the respective roles of the people described in the extract. She establishes an MCD using Collection K, including the professionals (doctor and nurse), who are referred to following the initial distinction 'I heard a doctor saying to the nurse', as 'they', and herself and her husband. The institutional identity, 'they', is used

[50] After this question IE asks 'Am I on?' which IR responds to before starting her response. The query and response from IR can be seen in full on page 202.

by IE to differentiate her and her husband's role and responsibilities from the hospital staff. Although she says 'doctor' and 'nurse', she categorises them as a duplicatively organised unit of which she and her husband are not a part. IE demonstrates her responsibilities as a member of Collection R, containing herself and her husband. A rule of the MCD that IE sets up here is that one member of Collection R has a responsibility to raise issues of concern regarding another member of this collection. IE sets up some rules regarding how such issues can be raised[51]. The interaction between the professionals and her husband is distinguished from her interaction with them in this extract. She does not describe any interaction with him here. His role is constituted as a passive recipient of the decisions of the professionals as can be seen in lines 3-4, 'they admitted him'.

The extract centres around 'the lesion on the lung'. This can be seen in the way IE mentions it at the beginning and the end of the eight-line extract. Although other activities are described in lines 2-6, IE can be seen to constitute the lesion on the lung as the key concern in the way she carefully constructs her description of the behaviour of herself and the health professionals regarding it. This is in comparison to the events described in lines 2-6, which are set out as a relatively straightforward and discrete sequence of events. IE describes the pain in the toe and the blockage in the groin as one problem by binding them together (lines 5-6). There is no repetition (unlike the lesion on the lung which is mentioned twice), and they are dealt with in a specific time span – Monday to Wednesday. It is not constituted as a delicate matter.

IE treats the lesion on the lung differently. In line 1, she initially raises the lesion as of potential importance by saying that the doctor spoke to the nurse about it. Health professionals have raised it, indicating that it has medical significance. It is something

[51] She does not describe her relationship to 'he' here, but we know from earlier in the interview that 'he' and 'me' are partners. IE does not explicitly identify this, but demonstrates it through her categorisation work. For example, her description implies a close relationship with 'he'. 'He' can be heard to be an adult as he is expected to do something about the pain in his toe. After several months of not doing anything about it, IE describes making 'him' go to the hospital.

the doctor considered was worth mentioning to the nurse. IE does not leave it to the health professionals to come back to later, but makes a point of raising it with them. She ties their decision to do tests on the lung to her mentioning the lesion through the use of 'then' in line 7. However, she can be seen to understate her involvement. One way she does this is by being unspecific about when she mentioned the lesion to the health professionals, saying 'in the meantime' in line 7. In this way, although she constitutes the lesion on the lung as of greater concern than the other medical problem, she downplays her response to it, by not specifying when she spoke to the health professionals about it. Raising the issue of the lesion on the lung is constituted as a delicate matter, in that IE could potentially be heard to be criticising the behaviour of the health professionals, which is something she works to avoid.

IE has to deal with a conflict of roles, as a lay member of Collection K and a member of Collection R. As a lay member of Collection K, it is not her role to have professional (medical) knowledge. Her role as lay member of Collection K conflicts with her role as a member of Collection R, which is to be an advocate for her husband and ensure he gets the appropriate health care. The delicacy of the matter is constructed around this conflict. In assuming greater knowledge than the health professionals, i.e. that the lesion on the lung was a serious medical problem that required investigation, she could be charged with interfering in matters she is not in a position to know about on two levels. The first is that the health professionals may be dealing with the lesion behind the scenes. The second is that, as it was not discussed with her, she does not officially know. She further adds a disclaimer in line 2, prefacing her first mention of the lesion on the lung with 'something about', down playing it, making her knowledge out to be unspecific. This works as a warrant for using a technical term, again emphasising her role as a lay person (who would not normally use such terms).

To deal with her conflict in roles, IE makes the description of her behaviour and that of the professionals ambiguous. Just saying 'in the meantime' makes it sound like it was quite informal, and non-threatening to the health professionals. This is in comparison to the description of the other medical problem and treatment, where specific days are

given. She does not say whether she mentioned it to the doctor or nurse, or both. Saying that she 'mentioned' rather than asked about it also works to understate her role in relation to getting the lesion on the lung seen to. Her description of the respective behaviours of the health professionals and herself here regarding the lesion on the lung can be seen to be a very cautious criticism of the health professionals.

The device used by IE here is described by Bergmann (1992) as 'litotes', or understatement. It is a rhetorical device that may be used by interactants to locally produce an analysis of, and orientation to, the context that is simultaneously reproduced in and through their actions. Use of this device enables the speaker to avoid specifying what is being talked about. In the case discussed here, it allows IE to avoid being seen as making decisions not appropriate to her role as a lay member of Collection K. Litotes means that the description in which it is used is presented as a cautious description. Bergmann demonstrates how litotes is used in psychiatric consultations to introduce delicate matters. It is generally regarded as an 'intersubjectivity invoking device' (p151). Bergmann goes on to comment on the construction of discretion in accounts:

> Viewed sociologically, there is not first an embarrassing, delicate, morally dubious event or improper behaviour about which people then speak with caution and discretion; instead, the delicate and notorious character of an event is constituted by the very act of talking about it cautiously and discreetly. (1992: 154)

This is the case in the extract above, where IE can be seen to constitute part of the activity described as delicate (regarding the lesion on the lung). The way in which the matter is constituted as delicate becomes clearer when it is compared with the way in which other activity in the extract is reported in a relatively straightforward manner, with specific details given such as times.

In the way she actively constructs, manages and uses ambiguity in her description of events, IE orients to considerations of recipient-design (Sacks et al., 1974). Ambiguity has an effect on the way in which IR may hear the account. It may also be heard in the way IE constitutes her experience (involving the behaviour of others and self) as

ambiguous (i.e. with no clear cut answers) and then manages this to present a reasonable account of her own behaviour. Here the situation is left as ambiguous for both speaker and hearer. In this way it is presented as reasonable. The speaker uses the ambiguity to constitute her own behaviour as reasonable, i.e. she made the right decision(s) given the circumstances. If IE had directly criticised the doctor, she could be charged with interfering, assuming knowledge not associated with her role (as lay person). Following Drew's (1998) point discussed earlier, she both orients to the fact that her account will be evaluated, and provides a basis for evaluating how the situation that is described should be evaluated by the recipient(s).

There are many possibilities available to the hearer as to why the health professionals acted as they did. For example, they may have needed to sort out the toe first as this may have caused problems for treating the lung lesion. The hearer is not given information about this, which is in line with Sacks's (1992) comment that speakers design stories in an extremely economical way. Parts are to be used by the listener to establish what will happen. Things are not just mentioned. However, if IE had not pursued her concern, she would not have fulfilled her role as a member of Collection R, a wife caring for a sick husband. What if her husband had got worse, the health professionals did not investigate the lesion, and she had not intervened? The situation is constructed as finely balanced, and consequently a delicate matter. There are similarities with Silverman's (1997) analysis of an HIV test counselling interview.

Extract 3.2 (Silverman, 1997: 78)

12 P: she's just told me (.)
13 that she had sex with (.) a [Xian] when she was out there
14 well not actually had sex with but this she said
15 that this guy (0.2) this is what she told me this
16 guy had (.) forced herself (.) hisself upon her

The client has gone for an HIV test because his girlfriend apparently had unprotected sex with a man while on holiday. However, the way he describes this is interesting in that he constitutes himself as not being in a position to know exactly what happened. As

Silverman suggests, he organises his description in such a way so as to not come across as too trusting, but at the same time not distrusting, therefore avoiding the charge of being what Garfinkel (1972) calls a 'judgemental dope'. This creates ambiguity for the hearer who is left to either believe or disbelieve his girlfriend's story, allowing the recipient to go along with either conclusion. This can also be seen in Extract 3.1 above, where IE balances her roles carefully ensuring that she is not seen as someone who will automatically assume that the professionals are right. As a member of Collection R, she also has a role to play in the accurate diagnosis of symptoms, even though she is not formally invited to do so by the health professionals. However, this role has to be negotiated by the member(s) of Collection R.

In Extract 3.1, it can be seen that IE constitutes raising an issue which falls in the domain of professional knowledge as delicate. A lesion on the lung is not a sign that a lay person would be able to see and comment on. She was not directly involved in the doctor-nurse conversation, though was near enough to hear what they said. She partly constitutes raising it as delicate through saying 'they didn't discuss it with me'. This is also ambiguous, in that the hearer is left to decide whether they should have discussed it with her. Alternatively, was she eavesdropping and heard it when she should not have done? She also does not know exactly what the problem is, saying that she heard them saying 'something' about it. We can assume that she did not raise the issue directly after hearing it, as she describes the other investigations and treatment for the pain in the toe, and then says 'in the meantime I mentioned the lesion on the lung'[52]. It would seem that this occurred sometime during the admission. She keeps it recognisably vague.

IE uses ambiguity to construct her behaviour in raising the issue of the lesion as a reasonable thing to do. This is delicate as although there is considerable activity described in lines 1-7, IE does not mention being involved in the decision making by the

[52] Atkinson (1994) has argued that there has been an overemphasis on the doctor-patient consultation as a place where decision making takes place. His study of medical talk in other settings demonstrates the considerable medical work done in other sites such as informal discussions between doctors. The situation described in Extract 3.1 indicates that it may be valuable to look more broadly at how patients and carers pick up personal medical information in settings other than the consultation, for example through observation and listening to 'unofficial' talk.

health professionals. She describes a potential role conflict between being an advocate for her husband and a non-professional member of Collection K. We know she overheard indirectly about the lesion on the lung. She constitutes it as her responsibility as a member of Collection R to query it on behalf of her husband. She is careful not to directly criticise the health professionals for not raising it. The hearer is left with several options to consider in relation to the reasonableness of the behaviour of those described. One is that it was the role of the health professionals to have shown greater concern about the lesion on the lung, and that they therefore warrant criticism. Another option is that IE is to be commended on her tenacity in relation to the lesion on the lung, despite the difficulties faced in raising it, and consequently the delicacy of the matter. In this sense then, the pervasive character of discretion, or use of caution in doing criticism, may become an important interpretive resource for the speaker. It also has major implications for how it is heard.

It has been shown here how litotes is used to describe negotiation of care by the bereaved spouse with the health professionals. As such it is constituted as a delicate matter, though in a different form than that of the psychiatric interviews that Bergmann describes. Collection K is drawn upon to clarify roles of professionals and lay persons. However, specific responsibilities attached to such roles are set up in relation to the situation described.

The level of caution used in doing the criticism depends, at least in part, on the commonsense knowledge or evidence available to (lay) members. The next three extracts involve a demonstrably less cautious approach than the one above. Nonetheless, this is not out and out criticism, it is still cautious.

3.3 Less cautious criticism

Extract 3.3 (Interview 1)

IR make some notes as well (.) [as well as tape recording it (.) I'd like you to (.) it
IE [yeah
IR the first question I'd like to ask is for you to tell me (.) the story of what happened if you wouldn't mind (0.4) just to kind of give me an idea (0.2) [and then I'll
IE [well
IR come onto more specific questions (0.2)

1 minute 30 seconds into the tape. Story to this point: IE gets a call saying his wife has collapsed in the village. He goes to hospital with her in the ambulance. She is taken away to be examined. After an hour and a half he asks a nurse how she is. He is taken to her and she is sitting up looking well.

1 IE and er a doctor came in and she said to me 'we've given your wife a
2 thorough examination we can't find anything wrong with her' (0.3)
3 which seemed a bit odd to me (0.2) you know they didn't (0.2) X-ray her
4 or anything like that (.) now why I've pointed this out is because (.) my
5 daughter (0.2) she read a case in America where an American man he
6 collapsed with a stabbing pain in his back just like my wife did (.) they
7 took him to hospital X-rayed him and found he'd got lung cancer (0.5)

In lines 1-3 IE sets up an MCD to describe a query about his wife's early medical care. He sets up a category set (Collection K) which includes health professionals and lay people (patient and patient's husband). An additional SRP is set up, including patient's husband and daughter. Two sets of categories are described, lay persons (members = IE and daughter), and cancer patients (members = wife and American person). He can be seen to query and criticise the medical care given to his wife. However, as in Extract 3.1, he does not do this directly, and avoids the available charge that it would be unreasonable for him (as a non-professional) to do it.

He can be seen to link the categories, stabbing pain, cancer and X-ray together to demonstrate his point. The categories are carefully selected to do the description as can be seen in Figure 3.1 below.

Wife had stabbing pain	American had stabbing pain
Wife had examination	
No X-ray	American had X-ray
Nothing like an X-ray	
Found nothing wrong	Found lung cancer
Died from lung cancer	

Figure 3.1 - Lay comparison of two cancer cases (used in cautious criticism of health professionals)

The behaviour of the professionals is criticised through the way IE uses categories to describe the events surrounding his wife's hospital care. Although the criticism is still cautious, it is less so than in Extract 3.1. Here IE is not describing a conflict between the lay person's roles and responsibilities associated with Collections K and R. Rather he describes a perceived incongruity between expected and actual (as described by IE) behaviour of the professionals. This is resolved through IE constructing the description as ambiguous. He does not say directly that the decision of the hospital staff was wrong. Such a comment could be heard as unreasonable given that as a lay person, he does not have professional knowledge. He resolves the problem he has raised (that his wife should have had an X-ray given her symptoms) by constructing it as out of the ordinary, 'seemed a bit odd to me' (line 3).

This is another example of litotes or understatement. The hearer is presented with two choices, to accept that the decision by the hospital staff was correct, or to consider the alternative possibility, that the appropriate decision would be for his wife to have had an X-ray. In this way it becomes the hearer's problem, and the account of the event by IE remains reasonable.

IE also uses direct reported speech as a resource in doing his criticism of the health professionals. Direct reported speech has been identified as a feature of complaints in

everyday talk (Holt, 2000[53]; Drew, 1998). Drew's (1998) analysis of everyday talk showed that what the person is quoted as having said is used to represent the transgression[54]. In addition, the words are left to speak for themselves. In Extract 3.3 IE uses direct reported speech on lines 1-2, reporting that an examination had found nothing to be wrong with his wife. He then goes on to assess this as 'odd' (line 3), before telling the story of the American man. As with Drew's analysis, what is quoted is used to represent the transgression. The person making the complaint does not explicitly attribute an evaluative term to the reported speech. However, the words are not left to speak for themselves, an explanation is given. Here IE relates what the doctor said to the lack of an X-ray and his wife's subsequent death from cancer[55].

IE draws on institutional identities to add emphasis to the criticism. In lines 1-3, we see that IE introduces the doctor, 'a doctor came in', directly. The doctor (through a description of her talk) is constituted as a representative of the hospital through his use of the term 'we'. This could be taken to refer to other hospital based health professionals, or just doctors. We are not told about this and it is therefore kept ambiguous. IE does not criticise the individual doctor, but 'they', who can be taken to be the hospital staff. Doing X-rays and things like that can be heard to be work associated with hospital staff. It is a category-bound activity. It is commonsense knowledge that X-rays are normally only carried out in hospitals. This is interesting in

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[53] Holt found that direct reported speech also recurs in 'telling amusing stories' (p425).
[54] An example of Drew's (1998) data is given below:

#24 [from #9] Drew, 1998: 319-320
1 Lesley: → He came up t'me 'n he said Oh: hhello Lesley, (.) still
2 → trying to buy something f'nothing,
3 ( ): .tch!
4 Joyce: .hh-[hahhhhhh!
5 [-.hhohhh!

[55] Antaki and Leudar (2001) have also shown how direct reported speech is used in parliamentary debates. Politicians use the exact words of opponents as reported in official parliamentary records to exploit the identity of the quoted source, to produce a dramatic or comic effect. They comment that: 'The rhetorical effect in all cases is that such words are especially unchallengeable, and the fact that they are sourced from an opponent's own mouth makes the message they carry immune to attack as interested or partial' (p467). The interviewees in my data do not have official records to hand and could lay themselves open to challenge regarding the accuracy of their recall. However, they use direct reported speech judiciously. The direct reported speech is presented in short 'sound-bites', making it hard to query their precision.

relation to line 6, in which it can be seen that IE introduces 'they' again, but this time does not specifically mention a doctor. We could potentially hear 'they' here as one of a number of category groups, e.g. relatives, people in the street. However, 'they' is to be heard here as 'health professionals attached to a hospital', as IE ties the 'they' who took him to hospital, to the people who carried out the X-ray. So, in the American case, 'they' took him to hospital, 'they' X-rayed him, and 'they' did the right thing.

The description in the extract is produced as a story. It can be heard as a bounded sequence with a clear beginning and end point. IE presents an action on the part of a doctor, reporting that she said that 'we' cannot find anything wrong with his wife. This could be treated here as part of the general interview account, a report of one of a series of events. However, IE adds a comment about the doctor's action, saying 'which seemed a bit odd to me'. In this way he uses the report of the doctor's action as the basis for telling a story. It enables him to explain why he thinks the doctor's action was 'a bit odd'.

Members produce problems in their descriptions, for which they provide solutions. IE can be seen to explicitly do this here, stating, 'now why I've pointed this out is'. It is not expected that the hearer will appreciate his meaning without him adding an explanation. Storytelling is an interactional business in which the speaker sets out to get a point across (Sacks, 1992). IE makes his story relevant to his ongoing account of events. As Sacks comments, 'it isn't just another description put in there for the hell of it' (1992; LC2: 13).

This story is neatly ordered. It is important for others to recognise that it is a story otherwise the recipient may wonder why a story about an American man is relevant here. IE constitutes it as of interest, through his preceding account of his wife's experience. Orderliness comes from the fact that it is 'specifically intended by the teller and collaborated in by the recipient' (Sacks, 1992; LC2: 227). IR is seen to collaborate by listening and not querying the points IE is making. IE uses 'intersubjectivity' as a recipient-design device. Intersubjectivity is taken by Schutz (1970) to refer to what

people take for granted in daily life. This can be seen in line 3 above, where IE says `you know', drawing the interviewer in. IE uses this category as a way of reasoning that the interviewer is basically a person like him 'endowed with consciousness and will, desires and emotions' (Schutz: p319). As Schutz comments:

> The bulk of one's ongoing life experiences confirms and reinforces the conviction that, in principle and under "normal" circumstances, persons in contact with one another "understand" each other at least to the degree to which they are able to deal successfully with one another. (1970: 319)

Intersubjectivity is used here to present the recipient with a possible explanation that can be accepted as evidence, in Drew's (1998) terms, of the rightness or wrongness of the health professionals' actions. Through this, IE creates a recipient-designed account, organising his description in such a way that criticism of the hospital staff appears to be well grounded to any sensible hearer. All he has said in the way of his doing the criticism is 'seemed a bit odd to me', which is not sufficient to be taken by the hearer as IE criticising the hospital staff. The term 'a bit odd to me' also is used to invite an intersubjective response from the interviewer. A strong criticism is implied, but IE is careful not to make it direct, i.e. to say that what the health professionals did was wrong.

Saying 'seemed a bit odd to me' marks up the lack of X-ray as something to be possibly queried by the hearer as well as the speaker. IE builds on this in lines 3-4, using another marker, 'now why I've pointed this out' to direct the hearer's attention to what he will say next, but tying it to the oddness of the lack of X-ray. If IE just noted that the doctor came in, said they couldn't find anything wrong, and didn't give an X-ray or anything, and then went onto say that an American man had a stabbing pain, had an X-ray and had lung cancer, it would be much harder work for the hearer to decide what IE means. In fact, the hearer might well say 'so what, people get ill and have X-Rays all the time'. It can therefore be seen that IE produces a context that is important in order for IE to establish his meaning, and for the hearer to understand it.

Sacks (1992: LC2: 227) raises a number of points regarding the production of stories which are useful in understanding IE's actions in producing the story of the X-ray:

- How is it that telling a story is relevant to the talk one does?
- How is recognition that a story is being produced relevant to the hearers?
- Why does the possible fact that a story is being told matter for the telling of it?

From the analysis discussed above we can see that setting up his talk as a story is central to IE producing a criticism of the doctor's action that was reported in lines 1-2. Recounting it as a story makes it relevant to the talk the speaker is doing. A number of points need to be understood in relation to each other. It is also important that the hearer recognises it as a story. IE presents his story in such a way that he is not directly critical, but leaves it to the recipient to decide. Finally the fact that it is a story means that its point is made apparent. The point here is that the health professionals were not thorough in their medical assessment of his wife.

This particular story is one in which MCDs are set up in relation to professionals, who although ascribed certain responsibilities and obligations by IE do not fulfil them. This differs from Extract 3.1 in which the description of roles and responsibilities was made much less clear, and which involved much more caution on the part of the speaker. By creating a category set, 'cancer patients', which is duplicatively organised, IE enables the hearer to observe the absence of the appropriate treatment (the X-ray). His wife and the American man were both cancer patients and if the American man had an X-ray why did his wife not have one?

The role of category sets is explored by Cuff (1980) who suggests that when a single party reports on troubles of a unit in which they are a member, both they and the hearer have available the possibility that the account is one-sided. Therefore for the description above it can be taken that other versions of what has happened may be standardly available and that paying attention to this possibility in the account assists the listener in hearing it as morally adequate.

IE can be seen to use his identity as a lay member of Collection K, who is being given information about his wife, to manage the incongruity between expected and actual behaviour of the professionals. The actual behaviour of the professionals in assessing his wife's condition is bound to the expected behaviour through the use of the lay person's category 'seemed a bit odd to me'. The 'seemed a bit odd to me' contributes to the overall sense of the account by building up a description in which IE is fulfilling his obligations as a member of Collection R in observing her care by others. He does not incur the charge that he did not do anything at the time, but by constituting his membership as a lay member of Collection K, demonstrates that he had limited power to speak. He uses his membership of Collection K to criticise the behaviour of the professionals, without attracting the charge 'what would you know, you're not a professional'. He is not a professional, but he does have commonsense knowledge available.

Commonsense knowledge of medical matters, as can be seen in Extract 3.1 also, is constituted as relevant and therefore important knowledge, although it is not automatically recognised as such by the professionals, especially in relation to Collections R and K. It has significance for the course of the illness. For example in Extract 3.1, IE designs her account in such a way that the listener may hear her concern with having her husband's lung problem investigated as greater than that of the health professionals, though this is ambiguous. IE does similar work in Extract 3.3.

Discussion of this extract has further shown how Collection K is used to define the roles and responsibilities of lay and professional members in relation to particular local contexts. It is used as a device in doing criticism. By using ambiguity IE constitutes it as cautious, rather than direct criticism, though it is less cautious than in the previous extract. Telling a story about the events which occurred allows IE to construct an account in which what the health professionals did (or rather did not do) can be heard as crucial. The critical implications of the description are clearer, but it is up to the hearer to decide whether criticism is warranted or not. In this way the production of the

criticism is collaborative. The next extract is a further example of less cautious criticism.

Extract 3.4 (Interview 4)

IR's question was not recorded and is therefore not included here[56].

5 minutes 30 seconds minutes into the tape. Story to this point: IE's husband had flu symptoms and after going to the GP twice, IE goes down there as he has lost weight and is very cold. Husband is referred to chest clinic, has an X-ray, and is given antibiotics for the first time. Three weeks later another X-ray reveals a tumour. He has an operation to remove part of his lung. A couple of months later IE's daughter finds her husband collapsed. He is admitted to hospital and has two more operations from which he recovers well. He went back to the other hospital and they are told by a cancer nurse that he has cancer. Her husband took the news very well. He is transferred to a specialist cancer hospital for radiotherapy.

1 IE they transferred him for a week's radiotherapy to the ((names hospital)) (0.4) so he was in
2 there (0.2) for about (.) just over a week I think it was (0.5) nothing was said
3 nothing was told they (.) they (.) wonderful hospital but (0.2) no (0.3) no
4 sort of information nothing (.) to me (0.4) whether they did to my husband I
5 don't know

Here IE sets up a criticism of the lack of information given to her while her husband was in a particular hospital for a week. She initially uses the institutional identity 'they' on line 1, which although she does not describe it, we can hear as referring to a hospital. It is commonsense knowledge that people are usually transferred from institutions such as hospitals, and not from home. It is implied that she was not involved in the decision to move her husband. She then sets up an MCD with the category 'information' and members of Collection K. She constitutes herself as a lay member of Collection K by emphasising, through the use of 'nothing' three times, and 'no' twice (lines 2-4), that as a lay member of Collection K she could expect to receive information. She does not actually say that she wanted information, that information is expected, or what form it should take. However, by saying no information was given, she makes the absence of

[56] Analysis of the 25 interview openings presented in Chapters Six and Seven indicates that it is likely to be similar to the other openings.

information programmatically relevant, creating an SRP of categories, one of which is missing.

By stating that something is absent, the hearer can recognise that it should be there. Here IE creates a rule that lay members of Collection K can expect to receive information from professional members of Collection K. This is a role ascribed to them by IE. As such she sets up the absence of information as a criticism. However, IE expresses her criticism of this lack of information with some caution. She does not directly indicate that she is criticising the hospital. She provides no detail as to what information should have been provided or who should have provided it, implying that it should have been provided by the hospital. She does not tie her desire for information to the radiotherapy. In this way she keeps her criticism ambiguous.

IE praises the hospital, but in a non-specific way through a category modifier 'they are a wonderful hospital' (line 3). This praise is sandwiched between comments that there was no information. Despite the hospital being 'wonderful' her criticism still stands. She is not criticising the hospital overall, but has a specific (reasonable) point to make. That it is a specific point is contributed to by using the link 'but'. If she did not say 'but' potential confusion could arise for the hearer, as she would be saying two contradictory things – 'wonderful hospital/no information'. Her lack of specificity apart from 'no information' keeps it ambiguous, making her criticism general. She constitutes it as reasonable to expect information as the wife of a sick husband. However, she uses the SRP husband-wife to suggest a separate possibility, that her husband may have received information in her absence or without him telling her. Despite this possibility, she sets up a rule that it is reasonable to expect information from the hospital (not her husband), as the spouse of a sick patient[57].

The description here does not follow the work done in Extract 3.1, where IE describes raising an issue with the health professionals. She constitutes the lack of information as

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[57] The policy issues regarding carers' rights to information are discussed further in Chapter Nine.

a criticism, but does not include the possibility of asking for information herself. Again this is ambiguous, as she does not mention contact with any individuals whom it would have been possible to ask. We do not know if she had an opportunity to ask, or she just did not ask. The absence of such a rationale (for not asking for information) is tied to commonsense knowledge available to the hearer that it is normal for lay people not to ask for information from professionals unless you have a specific question to ask (or if invited to ask a question). In Extract 3.1 it can be seen that although IE did have a specific question to ask (about the lesion on the lung), she constitutes raising it as a delicate matter. In Extract 3.4 IE does not constitute the situation as delicate, but she does use ambiguity, which constitutes it as a cautious criticism.

The following extract is another example of criticism that involves use of Collection K to define roles and responsibilities. It is not direct criticism in that ambiguity is used to achieve it, however, it is less cautious than the previous extracts.

Extract 3. 5 (Interview 5)

IR Could you tell me the story of what happened (0.2)

IE You've just read it in there [heh he was yeah he was [diagnosed=

IR [I know I have

IR =just brie[fly

2 minutes 30 seconds into the tape. Story to this point: IE's husband was diagnosed two years before he died. She and her husband went to the GP to get the results of an X-ray and a locum GP told them he had lung cancer. The cancer is inoperable and they query possible causes. Her husband had no pain at all. The local hospital was excellent. They put him on steroids having admitted him via an outpatient appointment. The steroids improved his symptoms. He went home twice from the hospice which she was pleased about because she found it difficult to cope looking after him at home. She describes a lack of concern from the health centre who are said not to assess and take account of the needs of carers looking after someone at home.

1 IE but (.) when it was confirmed as a stroke (0.2) well so called confirmed we said it
2 looks like a stroke to the doctor down there (.) and he said 'it would seem so' they
3 were his words 'it would seem so' (.) but really it was a bit of the lung cancer
4 (.) I mean I don't know the technical terms for it (.) but it was the lung
5 cancer reaching the brain as it was did Roy Castle (.) and course it wasn't
6 until after a few days that we realised what was happening (0.2) we didn't
7 understand it well we're not medical people are we? you know (0.8)

IE sets up an MCD including the SRP 'doctor' and 'we', the professional and lay members of Collection K respectively. She constitutes 'we' (line 1) as an institutional identity, comprising lay members of Collection K. She does not specify here who 'we' are. IE uses ambiguity, to strengthen her description of events by implying that it would be supported by non-specified others, i.e. it was not just her view that it was a stroke. The ambiguity lies with the mystery surrounding who 'we' are. It could be other lay people such as relatives, or friends, or her husband. However, if she specified her husband, she could be queried over the effect of his 'stroke' symptoms on his level of awareness. The use of 'we' reinforces the identity of IE as a lay member with a particular role and responsibilities. Whoever 'we' are, it is made quite clear in line 7 that they are not health professionals.

A rule is constructed that lay members, as non-medical people, are not expected to make accurate medical diagnoses, but the doctor as a professional is supposed to have expert knowledge (and make accurate medical diagnoses). IE uses the categories, possible diagnoses ('stroke', 'lung cancer'), and confirmation of diagnosis ('seems so'). The lay members of Collection K ('we') have the responsibility of highlighting problems and symptoms to the doctor or medical people, who will then make an expert decision. Accurate diagnosis is constituted as the responsibility of the doctor as can be seen in lines 6-7. A rule is set up that a lay member of Collection K is responsible for highlighting symptoms and presenting them to the professionals (doctor) who will be responsible for making accurate diagnoses. In this way the initial misdiagnosis is presented in lines 1-2 as lying at the door of the doctor, and the actions of the lay members are reasonable given the circumstances.

IE further defines her responsibilities in line 4 in which she states that she does not know the technical terms for this particular aspect of her husband's illness. A lay person is not expected to know technical medical terms. However, a lay person can recognise symptoms and relate them to commonsense knowledge. In this way they use their commonsense knowledge of medical matters. IE does this by describing what happened, the lung cancer reaching the brain, and how the lay diagnosis was made through relating the symptoms to a popular figure with similar symptoms who had lung cancer (Roy Castle). This is similar to the way in which commonsense knowledge, regarding the 'American man', is used in Extract 3.3. IE sets up a problem - the stroke symptoms (lay diagnosis - medical diagnosis), a solution - lung cancer reaching the brain (lay diagnosis), and an explanation for initial inaccurate lay diagnosis - lack of medical knowledge. IE does not provide any information regarding confirmation of the real diagnosis. Again this fits Sacks (1992) discussion of the way in which members use information economically. The 'buts' on lines 3 and 4 emphasise the doctors' misdiagnosis, rather than the lay people's misdiagnosis. IE constructs a description for the hearer, which constitutes her behaviour as the speaker as reasonable. She defends her actions and through this produces a criticism.

The inference in the latter part of the extract is that the lay members ('we') made the final correct diagnosis rather than the doctor, though this is constituted as something the doctor should have considered straightaway. It is not the responsibility of lay people to accurately diagnose medical symptoms. IE does not directly criticise the doctor, but can be heard to present a possible charge of misdiagnosis (or inadequate response) through repeating his response to the lay diagnosis 'it would seem so' twice. This marks up the lack of specificity in this response for the hearer. By saying 'they were his words' implies that they were his key words of response.

The use of the doctor's words is comparable with Extract 3.2 from Silverman's (1997) data (see page 69), in which the speaker emphasises that he is reporting what he has been told, saying 'but this she said.... this is what she told me'. This is stating the obvious, in that we know because he was not there, he can only know through what his girlfriend told him. In Extract 3.5 by saying 'those were his words', the inference to the hearer is that doubt could be cast on the validity of 'those words', making it seem fishy. The recipient is alerted to the possibility that there was something that may not be quite right about what was said. This is added to by repetition, as here the speaker says 'he said', and then 'those were his words' twice. It also establishes the speaker as a credible witness, as they can remember the specific words said. Here, as in Extract 3.3, the doctor's speech is directly reported. The use of direct reported speech in both instances is in line with Drew's (1998) analysis of the way reported speech is often used when complaints are made, with the quoted words left to speak for themselves.

Having raised the possibility of a charge of misdiagnosis or inadequate professional response through the device described above, IE keeps it ambiguous, leaving it to the hearer to decide whether criticism is warranted. The lack of any further diagnostic input from him at that stage is inferred by the following 'but really' in line 3, and 'course it wasn't until after a few days that we realised what was happening' in lines 5-6. IE does not say what the doctor should have done, but implies by the absence of any further comment than 'it would seem so' that he should have acted differently. In a sense though apparently making a strong critical statement she uses ambiguity to do her

criticism, leaving it to the hearer to decide. She uses Collection K to good effect. She does not say what he should have done, but through the absence of a correct diagnosis on his part, makes it programmatically relevant that he should have provided one.

We do not know whether the doctor visited or not, or what he did apart from apparently misdiagnosing the stroke symptoms. His actual involvement is kept ambiguous. However, we can see what the lay carers did against the absence of what the doctor did in Figure 3.2.

(symptoms) identified as stroke by lay carers
(symptoms) confirmed as stroke by doctor
(symptoms) not confirmed as stroke by lay carers
(symptoms) confirmed as lung cancer reaching brain by lay carers

Figure 3.2 - Setting up a criticism: lay and professional diagnosis

IE makes it clear through her categorisation work, that she (and the other lay carers) does not see making an accurate diagnosis as the role of lay people. The first part is that there is a technical term for lung cancer reaching the brain that is unknown to a lay person. The second is that the speed of recognising what certain symptoms mean is slower in lay people than professionals. Lay people 'realise' (line 6) what is happening eventually rather than diagnose. IE uses 'course' to further emphasise this (line 5). This highlights the way in which lung cancer can spread to the brain as something that is not uncommon - it happened with Roy Castle, and should have been considered as a possibility by the doctor. The third is specific, that lay people do not have the same expert knowledge as doctors (lines 6-7). She draws on intersubjectivity here, presenting it as a rhetorical question to IR, and adding 'you know'.

So far it has been seen how criticism is done using some level of caution. I have identified the relatively long and detailed extract below as an example of direct criticism, as the speaker describes it as such. However, it does involve considerable caution also, and is not as direct as it initially appears.

3.4. Direct criticism

Extract 3. 6 (Interview 4)

IR's question was not recorded and is therefore not included here (see Extract 3.3 which is part of the same interview).

6 minutes into the tape. Story to this point: IE's husband had flu symptoms and after going to the GP twice, IE goes down there as he has lost weight and is very cold. Husband is referred to chest clinic, has an X-ray, and is given antibiotics for the first time. Three weeks later another X-ray reveals a tumour. He has an operation to remove part of his lung. A couple of months later IE's daughter finds her husband collapsed. He is admitted to hospital and has two more operations from which he recovers well. He went back to the other hospital and they are told by a cancer nurse that he has cancer. Her husband took the news very well. He is transferred to a specialist cancer hospital for radiotherapy. She comments that the hospital was wonderful but she is given no information (see extract 3.4). He is transferred back to his local hospital.

1 IE The only criticism I have with ((names hospital)) when (0.2) the sister asked me to go in
2 the office (0.2) doctor turns up forget what his name was obviously a (.) hospital
3 doctor (0.2) came in (0.6) and said 'there's nothing more we can do (0.2) your
4 husband has got a matter of (.) we don't know weeks or days to live' (0.6)
5 though you knew it (0.3) it was so cold (0.4) the sister sorta I just (0.2) it was because
6 it was just John Blunt (.) straight out (0.2) couldn't cope with that (0.2) I sort
7 of hypervent I just I remember it I just couldn't (0.2) and he just walked out (0.2)
8 now I've got a criticism with that (0.3) I mean surely (0.2) er medical people whatever
9 (0.2) they can't just tell somebody they're going to lose their husband (.) and
10 then just walk out (0.2) I know he's a busy man (0.5) but (.) that is telling
11 somebody that their whole life's gonna change (0.4) and (0.4) I don't think (0.2)
12 I don't know whether this comes in heh heh in the study but I don't think
13 doctors are trained to cope with (0.3) telling people (0.2) such tragic news=
14 IR =Yeah (0.2)
15 IE and (0.2) yet I knew all the way along=
16 IR =Yes (.) yeah (0.4)
17 IE so that (.) but (.) as regards the care (.) nothing couldn't they couldn't be (0.2)
18 more attentive

IE sets her description out as a criticism from line 1, emphasising it again in line 8. However, though the criticism may be direct in the sense that she identifies it as such at

the beginning of the extract, the work she does around it is complex. She can be seen to constitute criticising an individual health professional as a delicate issue, similarly to Extract 3.1. It is not sufficient to say 'this is my criticism – the hospital doctor was insensitive'. It involves establishing a framework of moral accountability.

IE sets up her criticism from the beginning as being with an institution, the hospital. She sets up an MCD using an SRP, wife of dying husband and doctor. A second SRP, wife of dying husband and nurse, is also set up. The roles of the doctor and nurse are constituted as different here, though they are both representatives of the hospital. The criticism is not of the nurse who has asked IE to go into the office. The nurse's role is constituted as peripheral, in that her behaviour is described in a straightforward manner, as in Extract 3.1. The nurse's role here is not constituted as giving bad news, in this case to tell someone their spouse is dying.

Rules for a doctor telling someone that their spouse is going to die are specified. IE sets up a rule that a doctor imparting tragic news to someone should prepare the recipient first, not walk out after saying it, and should provide some kind of support afterwards. If this does not happen it is reasonable to criticise their behaviour. IE does work to prepare her criticism in lines 2-3. She uses several pieces of description that downplay the doctor's status, and emphasise the impersonal way in which the information was relayed. Saying he 'turns up' implies that it was not a formal meeting, that is, it did not seem important to the doctor. This combined with 'forget what his name was', and 'obviously a hospital doctor' infers that any hospital doctor could have given her the information. The inability of IE to cope with the information is specifically bound to the impersonal manner of the doctor (lines 2-3), and the directness of the information giving (lines 6 and 7). She states that she cannot cope with the way in which the doctor gave the information, saying it was 'straight out', and 'cold'. The interviewee here reports the doctor's words directly, but although they form part of her criticism she does not use them to mark up something fishy. This differs from the use of reported speech in extracts 3.3 and 3.5. In this case she says she has a criticism with the hospital, reports what the doctor says, and then explains why she has a problem with what he has said.

By locating her criticism in relation to the way in which the information is given, rather than criticising the information itself, or the person giving it, she avoids the charge of inappropriately criticising the doctor for not being able to do anything to save her husband's life, which could be heard as unreasonable. It is commonsense knowledge that many people cannot be cured of cancer.

IE also suggests that it would be possible to cope if the information was relayed in a different manner – 'couldn't cope with that' (my underlining). This supports her criticism and targets it. She provides proof that she did not cope in the form of a description of a physical response, hyperventilation. She also states that this is her only criticism of the hospital, which again emphasises and strengthens it. This suggests that she does not go about criticising for the sake of it, which makes her action here seem reasonable. If you only have one criticism, the implication for the hearer is that it must be an important one. She specifically states what she will be doing in this piece of description, focusing it for the hearer.

Although IE sets up an MCD with the SRP, patient's wife - doctor, and constructs rules around this SRP to do her criticism, she places it within a broader MCD in which the hospital and people who receive tragic news are members. In this way she does category bound activity work to constitute the activity of giving tragic news badly as the fault of the hospital, rather than the individual doctor. Though she describes the behaviour of the doctor, at the beginning of this extract she describes her criticism as being with the hospital. It would be difficult to blanket criticise the whole institution without being charged with being unreasonable. However, criticising the doctor would open her to the charge of being unreasonable in the light of the commonsense knowledge that there are many demands on doctors. She manages the potential ambiguity of this situation by setting up her criticism in relation to three separate categories, the hospital, the doctor, and medical training.

IE states that she is making a direct criticism of the hospital in line 1. She then seems to describe the behaviour of an individual doctor critically, but creates some ambiguity

around his identity, constituting him as any hospital doctor, as can be seen above. She in effect creates a kind of smoke screen around him that makes it hard for the hearer to identify what his responsibilities are. In this way IE uses ambiguity to minimise his role in her distress. She also binds his behaviour to the hospital. Therefore he as an individual is not to blame.

She goes on in lines 12-13 to identify where the blame lies, and it is with the inadequacy of medical training. Her criticism is of medical training, therefore the doctor is not to blame. It is possible to criticise someone, but not blame them for their behaviour at the same time. She is careful not to blame the individual doctor. As such she could be seen to constitute the criticism as a delicate matter. This shows how meaning is constructed locally through creating a context for the behaviour of the doctor. This can be further seen in line 13 in which IE uses 'cope' in relation to doctors training' to give tragic news. This is interesting, in that not only do lay people have to 'cope' with receiving tragic news but doctors have to 'cope' with giving it. She constitutes it as a two-way interactional process, which for the purpose here describes doctors and lay persons as part of the same unit which is duplicatively organised. Both parties have to cope with tragic news, though one gives and one receives it. IE constitutes the whole area of giving and receiving tragic news as multi-faceted. This is emphasised in line 15, in which she says she already knew what the doctor told her. We can take this to be bound to the events in lines 1-13, that her husband is dying, as she does not say otherwise.

The interviewee clears the individual doctor who gave her the news that her husband was dying from blame. Her case is that doctors are not trained to cope with telling people tragic news. In this way IE ties doctors not being trained to cope (line 13) with this particular doctor not coping (line 7). He is therefore not to be criticised, as he could not cope either. IE not coping is manifested as hyperventilating. The doctor not coping is manifested as walking out. In a sense she ends up by sympathising with the individual doctor, rather than criticising him. This again demonstrates the range of action, and complexity of meaning, that can be achieved in relatively short descriptive episodes.

IE says in line 1 that her criticism is about the named hospital, implying that she holds them responsible for what has happened. This is balanced in lines 17-18, in which it can be seen that the hospital is praised for the care they provided. It is of note that telling bad news is not constituted as 'care' here. She does not say 'as regards the rest of the care' or anything like that.

It is also of note that in lines 12-13, IE indicates that her understanding of what is required of her in the interview are views relating to her case, not general views on medical treatment and care. She includes this as a discrete but related view. She criticises part of the hospital's work in relation to her case, but does not constitute it as her role in this interview to allocate blame to individual doctors. The blame lies within the wider social context.

3.5 Discussion

The analysis presented in this chapter has methodological implications for two main areas, the production of criticism in accounts, and the study of 'dissatisfaction' with health care. The former will be discussed here. The latter will be discussed in Chapter Nine following the data analysis as a whole.

3.5.1 Using caution: implicit and explicit criticism

The analysis has examined how different levels of caution are used to produce criticisms of health professionals in qualitative research interviews. The way in which caution is used in producing criticisms can be considered in relation to the distinction between 'implicit' and 'explicit' moral work observed in everyday conversation by Drew (1998)[58]. He notes that morality may at times become the explicit topic of conversations

[58] Drew (1998) comments that the patterns observed in everyday conversation may be equivalents of activities which occur in institutional data, especially in 'medical or quasi-medical settings, in which the layperson's (e.g., patient's) detailing appears to be designed, quite implicitly, to portray themselves as being responsible, "good patients," "good mothers," and so forth, in circumstances where their actions might be regarded otherwise...' (p302).

– 'notably when co-participants are evaluating, and particularly complaining about, the conduct of others' (p296). Drew found moral purpose to be implicit when there is 'defensive self-description' (p296). In such cases speakers exhibit the propriety of their own conduct, but do not overtly claim it. This distinction between implicit and explicit moral accounting work found by Drew can be considered in relation to the different forms of criticism (the continuum) identified in this data.

In Extract 3.1 the speaker implies a very cautious criticism, in that she describes an omission on the part of the health professionals – they did not appear to be taking any action regarding the lesion on the lung. However, she situates it in relation to her action. This can be seen as defensive self-description. She details circumstances concerning the lesion on the lung. Drawing on Drew's observations, it can be seen that such detailing is defensive insofar as it may be designed to build a case for, and hence warrant, her having asked about the lesion on the lung. It casts her inquiry as a genuine inquiry, motivated by real uncertainty, rather than it being a criticism. As Drew notes:

> ...defensive detailing arises from the speakers' orientation to their own ongoing conversational conduct and to the prejudicial moral implications that might (otherwise) be attached to that conduct by the recipients. (1998: 302)

Drew raises the following methodological question:

> ...if the moral work that we can see being done in such instances of defensive detailing is implicit and does not come to the interactional surface of the talk between the participants, how can we (as analysts) make a case for that being the work of such detailing? (1998: 302)

He suggests that one way to begin to answer this question is to identify cases in which speakers clearly orient to the possibility that some (conversational) action of theirs may be regarded as a transgression, and imply the innocence of their conduct in the detail of their description. My analysis highlights more specifically how possible transgressions are set up, through the use of lay and professional identities, for example, in relation to responsibilities towards partners.

In comparison to defensive detailing, Drew found that when complaints were being made, the morality of conduct is treated very much at the interactional surface of the talk. Drew (1998: 309) identifies a number of features of complaint sequences: they are presented as distinct topics that are clearly bounded; the formulations of transgressions are explicit ('some normative standard of behaviour is explicitly invoked as the basis for complaining about someone's behaviour'); and moral indignation is expressed . This can be considered in relation to my data.

If we take the example of direct criticism in Extract 3.6 it can be seen that although IE explicitly describes making a criticism, she actively pulls back from formulating a transgression on the part of an individual (doctor). She builds a case for making a criticism, but does not end up producing a direct criticism. This is of course only one case. However, a similar description can be seen in an extract taken from a study of dissatisfaction with health care undertaken by Coyle (1999) which is replicated below[59].

Extract 3.7 (Coyle, 1998: 109 ((Mr Cuthbert (15))[60].

1 The doctor in the green overall came out and said, 'you've got cancer, we
2 can't cure you'. Just like that. Just after she's had a serious operation. I
3 repeat myself again, it's the lack of care, and not being treated as a
4 human being is basically what I've found, that is really the grudge I've
5 got.

The speaker describes his experience of his wife being told that she has incurable cancer. He sets it up as a criticism in three ways in lines 1-2. He uses direct reported speech to relay what the doctor said. As seen in relation to extracts 3.3 and 3.5 this can be used to suggest that something fishy is going on. He then adds 'Just like that'. This is used to

[59] Coyle analysed 41 interviews with patients, carers and relatives. Interviewees were also those waiting for treatment and those receiving it at the point of the interview. The focus of the interview was dissatisfaction with health care.

[60] The doctor mentioned in the extract is said to have 'informed the respondent's wife that she was dying from cancer in an abrupt and unsympathetic way' (Coyle: p108). Coyle uses this extract as an example of 'practitioners breaking tacit taken-for-granted rules of lay-professional interaction' (p108). In this extract the speaker has implied that the rules of communicating distressing information had been broken by the doctor. An important feature of the interviewee's account is that he not only refers to practitioner having broken the tacit rules, he also sets the rules up.

constitute the way the doctor broke the bad news as a criticism. A further contextual feature is added, 'Just after she's had a serious operation'. However, as with the interviewees in my data he uses ambiguity. He is careful not to criticise the actions of the doctor directly.

This is also evident in the way he sets up a rule for holding a 'grudge' (line 4). The grudge is about two things described in the extract, 'the lack of care' and 'not being treated as a human being' (lines 3-4). However, he implies that his grudge goes beyond the actions of the doctor described in lines 1-2. These categorisations are to be heard as general comments and as ways of summarising his experiences. This is indicated in the way he says 'basically what I've found', and 'that is really (the grudge I've got)'. It implies that the way his wife was told she has incurable cancer is an example of 'lack of care' and 'not being treated as a human being'. However, he uses ambiguity in that it is not clear whether he is talking about his wife not being treated as a human being, or both himself and his wife. He also makes it clear that this is a personal point of view and his grudge, hence he does not rule out that his actions or thoughts may be viewed as inappropriate.

Drew's analysis of everyday conversation distinguishes between implicit and explicit complaint sequences. However, although Drew's analysis has important implications for the study of the interview data, all the criticisms found in the data analysed here involve some level of caution. Even in the apparently direct criticism (Extract 3.6) the interviewee ended up avoiding making an explicit formulation of a transgression regarding the specific doctor who had informed her in an insensitive, 'cold' manner that her husband was dying.

The notion of caution has been useful in examining the work that the interviewees do in producing criticisms of health professionals. Criticisms are made in relation to lay and professional categorisations, meaning that the use of caution appears to be influenced by the institutional nature of the relationships described by the interviewee. For example, fault is implied within the contexts of lay and professional relationships, which involves

different types of knowledge. The position of the lay person in relation to the professionals means that it is hard to attribute clear fault to individuals, without attracting criticisms to one's own actions. This has implications for the study of satisfaction and dissatisfaction with health care (which are discussed in Chapter Nine).

3.5.2 Lay identity work in health care

The increasing interest in the role(s) lay people play in health care was briefly reviewed in Chapter One[61]. This interest is reflected in a recent special collection of papers published in the journal *Text* which took 'lay diagnosis' as its topic. The papers all involved CA, and all but one analysed consultation data[62]. In a review of these papers Drew (2001) comments that the studies show that 'patients are not docile, but have agendas of their own, which they pursue, through various communicative strategies, through the interaction' (p263). He goes on to consider the notion of delicacy:

> It appears that patients are quite conscious of the tenuousness, fragility, uncertainty, or vulnerability of their lay diagnoses, at least in terms of the medical view of doctors. Hence they recognize how sceptical doctors might be of their concerns. Their initiatives are being made perhaps against the weight of medical authority. This consciousness does not prevent them pursuing their initiatives, but it is manifest in the implicitness and cautiousness with which they approach certain matters.... Patients thereby treat their initiatives (making a request, introducing a concern) as *delicate*... insofar as they need to be communicated in a fashion which does not overtly challenge the doctor's authority. (Drew, 2001: 264)

Drew is referring to patients and doctors whereas my data are interviews with spouses of patients who have died, or 'carers'[63]. Another difference is that the data analysed here are criticisms of health care professionals not just doctors. However, analysis of the categorisation work that interviewees undertake in my data demonstrates that carers

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[61] This is happening at all levels, from the doctor-patient consultation to the committee level e.g. Primary Care Trust Boards include lay members. The interest here is on direct contacts between health professionals and lay people (patients and carers) during health care delivery.

[62] Drew comments that over the last 20 years a considerable body of research has been built up on doctor-patient interaction. However, this research has been largely doctor-centred, and that whilst censuring medical practice for silencing the voice of the patient it has largely ignored the role of patients in interactions with doctors.

[63] These people are often referred to as 'carers'. I discuss some of the implications of my analysis for policy regarding carers in Chapter Nine.

include accounts of the experiences Drew refers to in the interview data. For example, in my interview data *carers* are found to treat their initiatives (making a request, introducing a concern) as *delicate*. Category collections K and R are key resources used by the interviewees in the interview data to set up and differentiate between lay and professional identities[64]. This supports the value of undertaking categorisation analyses of interview accounts on health matters.

This chapter has demonstrated some of the detailed categorisation work that interview participants do in producing criticisms of health professionals. The interviewee does most of this work through their accounting practices but the interviewer is drawn into the production of the criticisms through the use of devices such as ambiguity and recipient-design. Even examples of direct criticism are not as direct as they seem to be on the surface. A range of resources are used in producing interview accounts, only a few of which have been described in this chapter. Criticisms are a product of assessment work carried out in the interviews. The way in which assessment work is accomplished in the interviews is the focus of the next two chapters.

[64] Interestingly, Drew et al. (2001) suggest that it may be possible in the future to make comparisons between detailed analysis of communication in medical interactions and interviews with patients about their expectations. This would inform what is known about patient satisfaction with care. The present analysis does go some way to demonstrating that the way in which carers describe their health care experience in interview accounts does correspond to some extent with practices observed in consultations (as described by Drew, 2001). Methodologically this is something that appears to warrant further investigation.

CHAPTER FOUR

ASSESSMENT WORK IN RESEARCH INTERVIEWS: PRAISING HEALTH PROFESSIONALS

4.1 Introduction

The preceding chapter focused on how a topic in the talk, criticism of health professionals, is produced in interview accounts. It demonstrated how interviewees use a number of different devices in order to construct their criticisms. These devices include the categorisation of lay people and professionals and recipient-design, both of which are pivotal resources in generating these criticisms. This chapter and the next build on the previous analysis, but this time attention is not focused on a particular topic identified in the talk (e.g. criticism), but on a more intensive analysis of the work that goes into organising the accounts themselves. This will be achieved by investigating how assessments and related resources are used in the interviews. The focus of interest is the 'machinery' (Sacks, 1992; LC2: 113) through which occurrences like criticism are accomplished in the context of these interviews. This is done by paying close attention to what participants actually say, through analysis of the underlying structures and procedures employed to accomplish the events they are engaged in (Goodwin and Goodwin, 1992). Attention to assessment work will go some way to finding out about 'how it is that persons go about producing what they do produce' (Sacks, 1992; LC1: 11) in the interview talk.

4.1.1 Organisation of Chapters Four and Five

These two chapters are presented as a pair. The present chapter initially introduces two devices that are commonly used in the interview data in conjunction with assessments, the course-of-action device and economy. The notion of assessments and how they are used in talk will then be described before moving on to a detailed analysis of two data extracts. The two data extracts analysed are accounts of the experience of the actual death of a spouse. The first is presented as a positive experience by the interviewee. Assessment work in this extract is explored in this chapter. The following chapter examines a longer extract where the experience of the death is presented as a negative one.

The data can also be seen as examples of praise and criticism respectively and are identified as such in the way the chapters are organised[65]. However, this distinction is secondary to the analysis of assessment work in the participants' descriptions. The central analytic feature of both chapters is how assessments get done. A discussion of the analysis of the assessment work carried out in these accounts is included at the end of Chapter Five.

4.2 Economy and course-of-action (devices)

Sacks (1992) makes the following comment about a data extract where one of the parties describes her experience of witnessing a car accident:

> We can also be noticing that what A does in her story is not just a report of an accident; she's reporting something which she saw and then did a bunch of work on (LC2: 11).

This is, of course, true of all accounts, but how does the "work" that Sacks refers to get done?

Sacks (1992) describes how storytellers use economy in designing their stories: 'Any parts put in can be used by a listener to find what further is going to happen. Nothing is just mentioned' (LC2: 238). However, this organised economy is unknown to the storyteller who may consequently be struck by it (Sacks, 1992; LC2: 239). Economy and the course-of-action device are often used together in the production of descriptions. The course-of-action device is described by Sacks (1992):

> ...the course-of-action organization involves employing a technique which makes it obligatory on the hearer, if they're going to understand the story, that at each point that a new feature in the course of action is introduced, they organize that new feature by reference to what they've

[65] I did not set out to produce two chapters about praise and criticism. The extracts were selected from a number of extracts in which the interviewees were doing some kind of assessment work. I decided to examine these two in more detail in terms of the interesting assessment work that the interviewees were doing. It is coincidental that the accounts are both about the actual death of their spouse and present quite different experiences. However, this serves as a useful comparison between different experiences of the actual death of a spouse.

already been told about where she is, what she's doing, etc. because the later parts in the course of action are not done in such a way as to bring one up to date with the earlier parts. (LC2: 232)

The use of these two devices can be seen in Extract 4.1 below.

Extract 4.1 (Interview 3)

IR You know the services you recei:ved and what hap some of it actually you've already told me so I can make a note of it but erm:

3 minutes 55 seconds into the taped interview. Story to this point: IE's husband had several courses of antibiotics for what was though to be a painful ingrowing toenail, with no improvement. IE takes him to hospital where he has a local anaesthetic in his toe. Goes back home and sleeps for while but then has to be taken back to hospital where they do 'about 12 tests'. A blockage in the groin is found related to the toe which requires a bypass. A lesion in his lung is also found and a biopsy done after IE queries having overhead this mentioned. A large operable tumour was also found and her husband decides to have the operation.

1 IE He had the operation done (0.2) and he was wonderful (0.5)
2 marv[ellous after the operation] (0.5) came home
3 IR [( )]
4 IE and 16 weeks later had his bypass (0.5) and had that done with an epidural (0.3)
5 IR mhm
6 IE and he had his two toes amputated (0.7) and he was fine again (0.2) until (0.8)
7 last (0.8) Easter when he got this pain at the bottom of the lung (0.6)
8 er then they suggested going on morphine (0.5) and (0.5) he went a bit vague
9 beforehand (0.2)

The nature of the events described in this extract as a course-of-action is evident in the way IE says 'had <u>his</u> bypass' (my emphasis) on line 4. It indicates that the hearer will understand what the bypass was about through being able to relate it to something raised earlier. Using the course-of-action device enables the speaker to produce an economical account. It means that IE does not need to explain the reason for the bypass here. Assessments are also used in constructing an economical account[66]. For example, IE can

[66] As are devices such as instancing and chronology which were identified as devices in the early analysis of storytelling undertaken for this chapter (see page 57).

be seen to produce a report followed by an assessment on line 6. The assessment here implies a specific local meaning for the report. The hearer would normally consider the amputation of two toes as somewhat distressing. However, the assessment states that 'he was fine'. The way in which the assessment is used here indicates that this is particular to this case.

IE provides further contextual information by adding two indexical expressions, 'again' and 'until'. In this way, she relates her husband being fine to the overall course of action of her story, rather than explaining each point she makes. No explanation is given here as to why he has had his toes amputated, which makes it clear that the hearer should already know. The use of 'again' (line 6) also reminds the hearer of what went before, i.e. she indicates that she has already defined what she means as 'fine'. As Sacks (1992) comments, it 'makes it the business of the hearer to keep in mind the sequential status of what's being told' (p232). Here IE links the past with the future saying 'fine again', to remind the hearer of what already has been said, and 'until' to shift the hearer to the future. This is explained by Sacks:

> ...there are lots of parts of stories which, while they're placed in a sequence, bear a needing-to-be determined relationship to what anybody would have or might have reported as events were occurring. They're not a narrative characterization of reality.... (1992; LC2: 237)

The lack of explanation at various points in members' talk is clearly noticeable, and in this way made relevant (see Sacks, 1992; LC2: 226).

4.3 Assessments

An assessment is an evaluation of events being discussed within talk (Goodwin and Goodwin, 1992). They show 'a speaker's evaluation or interpretation of some event, thing, or person' (Jones, 2001: 117). Pomerantz (1984) comments that assessments are produced as *products* of participation, such that with an assessment a speaker claims knowledge of that which he or she is assessing. Part of participating includes proffering assessments. When people take part in social activities they routinely make assessments, which means that participating in an event and assessing that event are

related enterprises. Assessments are based on the speakers' knowledge of what they assess. They are occasioned conversational events with sequential constraints.

Goodwin and Goodwin describe and discuss different types of assessments, which relate to their position and type. For example:

- Assessments that precede assessables, e.g. beautiful Irish setter
- Post-positioned assessments, e.g. he made a pie, it was so good
- Performing an assessment as a structured interactive activity, e.g. assessments as resources for closing topics
- Instigating, e.g. isn't Terry mad at me.

Goodwin and Goodwin, and Pomerantz describe the use of assessments in their sequential analyses of everyday conversation (using CA). In everyday talk assessments are often used to show alignment, affiliation and support (Jones, 2001). The focus here is on how they are used in interview talk. Let us consider how assessments, course-of-action, and economy are used as resources in interview accounts in relation to Extract 4.1 which is replicated below.

Extract 4.1 (Interview 3 – repeated from above)

1	IE →	He had the operation done (0.2) and he was wonderful (0.5)
2	→	marv[ellous after the operation] (0.5) came home
3	IR	[( )]
4	IE	and 16 weeks later had his bypass (0.5) and had that done with an epidural (0.3)
5	IR	Mhm
6	IE	and he had his two toes amputated (0.7) and he was fine again (0.2) until (0.8)
7		last (0.8) Easter when he got this pain at the bottom of the lung (0.6)
8		er then they suggested going on morphine (0.5) and (0.5) he went a bit vague
9		beforehand (0.2)

The assessments in this extract are used to make observations about certain events. For example, 'wonderful' on line 1 is bound to the operation. IE infers that it was perceived to be a success, though she does not say in what way. It is of note that she does not

make a similar type of comment about the bypass she mentions on line 4. She just mentions that he had an epidural. She is producing an economical account. IE does not need to provide an assessment in relation to every report she makes[67]. The assessments are an important resource used by IE to 'tell the story' of her husband's illness and treatment in the interview.

Goodwin and Goodwin explore how context is organised within turns at talk, and are particularly interested in the way assessments provide a resource that can be used to accomplish social organisation within turns, and to negotiate and display congruent understanding of the events they are dealing with, commenting that:

> Assessments provide an example of a small activity system that can emerge, develop, and die within the boundaries of a single turn, while also having the potential to extend over multiple turns, and to bound units considerably larger than the turn. Assessments also provide participants with resources for displaying evaluations of events and people in ways that are relevant to larger projects that they are engaged in. (1992: 181)

The potential for assessments to display evaluations that are relevant to larger projects can be considered in relation to Extract 4.1, where IE makes an assessment of her husband's response to having two toes amputated as 'fine'. The meaning of the assessment is to be understood in relation to the broader context of her husband's illness and death (from cancer), in which having two toes amputated is a relatively minor issue. It can also be seen that although IE is doing work that contributes to a larger 'project' (describing the death of her husband), she presents two assessment sequences which take the form of small activity systems. These refer to her husband being 'marvellous' after

[67] Why are assessments 'attached' to some of the reports made in the interviews and not others? Economy is a key factor. It would be tedious for the speaker and recipient to 'assess' everything. In relation to this extract I suggest that the assessments used in lines 1-5 both describe part of the course of his illness and response to it, and are presented as a relatively discrete description. This highlights the different nature of events described from the end of line 5, from 'until'. She is demonstrating what 'fine' is within the broader context of health and illness (it is relative). So though we do not get an assessment added to the report of pain in the lung, it is implied that this is not fine. She therefore organises her description so that a moral stance towards events is described. Here she sets up a difference between forms of illness in terms of their effect on her husband.

the operation, and 'fine' after the toe amputation. These assessments are to be understood as part of the story of her husband's death from cancer.

It was seen above how assessments may be used in the interview accounts to assess an event or situation, such as when IE states 'he was wonderful (0.5) marvellous after the operation'. Another way in which they are used is to assess the behaviour of the speaker, specific health professionals, and health professionals in general. It is the use of assessments in descriptions of such behaviour that will be examined in detail here. The primary focus of analysis in this chapter and the next is on how participants produce assessments. The titles of the chapters include the terms praise and criticism as the analysis of assessments involves explication of these topics in the talk being analysed[68]. However, the chapters are not intended to be read as analyses of praise and criticism. These topics are 'by-products' of the analysis (Sacks, 1992; LC2: 240)[69]. As Sacks comments:

> Most of the things that we consider as products, i.e., the achieved orderliness in the world of some sort, are *by-products*. That is, there is machinery that produces orderly events, but most of the events that we come across that are orderly are not specifically the products of a machine designed to produce them, but are offshoots of a machine designed to do something else or nothing in particular. (1992; LC2: 240)

Assessments are part of 'the machinery that produces orderly events'. An outcome of the assessment work in the extract below is praise of some health professionals by the interviewee.

[68] This was considered a useful way of presenting the analysis of assessments, and additionally is useful to the later discussion of the implications for the sociology of health and illness and policy in Chapter Nine.
[69] They are important by-products and have implications for how lay people make positive and negative assessments of their experiences of health care, which will be discussed in Chapter Nine.

4.4 Using assessments to praise health professionals

Extract 4.2 (Interview 4)

IR's question was not recorded and is therefore not included here.

8 minutes 50 seconds into the tape. Story to this point: IE's husband had flu symptoms and after going to the GP twice, IE goes down there as he has lost weight and is very cold. Husband is referred to chest clinic, has an X-ray, and is given antibiotics for the first time. Three weeks later another X-ray reveals a tumour. He has an operation to remove part of his lung. A couple of months later IE's daughter finds her husband collapsed. He is admitted to hospital and has two more operations from which he recovers well. He went back to the other hospital and they are told by a cancer nurse that he has cancer. Her husband took the news very well. He is transferred to a specialist cancer hospital for radiotherapy. She comments that the hospital was wonderful but she is given no information (see Extract 3.4, page 79). He is transferred back to his local hospital. IE criticises the blunt way she was told her husband was dying (see Extract 3.6, page 87). She asked if she could have him at home for his 'final days' but he died before this was arranged.

1 IE I was with him (0.2) when he died (0.8) whi::ch (0.2) I was very grateful (.)
2 never done it before and I (0.2) wasn't even frightened of it (0.5) and (0.5) it
3 wasn't that harrowing (0.2) I said as long as he wasn't in pain (0.7) erm
4 (0.8) and (0.2) they were very good (0.4) he died about 11 o'clock in the
5 morning (0.5) lovely girl on (.) 23 years old on her own (.) my God I
6 couldn't have done that (0.2) nothing like that at 23 myself (0.7) very nice (.)
7 nurse

This extract contains a number of assessments. I will analyse lines 1-3, which involve the speaker assessing her own experiences and behaviour, before moving onto the second part of the extract (lines 4-7) which includes assessments of health professionals. The analysis explores two main issues:

- Entitlement to report on a personal experience (drawn from the husband-wife collection);
- Lay and professional identity work (use of Collection K).

4.4.1 Entitlement to report on a personal experience

IE here describes the experience of being with her husband when he died. Initially she does this by reporting that she was there with her husband, 'him', when he died, that she was grateful, and that she had never done it before. The first and third reports invoke a context for the assessments that follow – 'I wasn't even frightened', and 'it wasn't that harrowing'. Reporting that she was 'with' her husband when he died implies a certain level of entitlement to experience or observation. She sets this up before making assessments. She defines her entitlement to this experience on two levels, as someone close to the person who died, and as a member of society. She distinguishes between personal and general experience.

IE indicates that she did not just watch what happened. She starts to set up this experience of death as a particular type of experience that is personal. When IE says she has never done it before she implies that she has never been with anyone when they have died, though we can hear it as commonsense knowledge that she may have witnessed deaths in different ways before. For example, we all have experiences of 'death' in the sense that we all know someone who has died or have seen it on television. However, being with someone when they die is set up here as a particular type of experience (of death). Reporting on being with a husband who has died is set up by IE as different than reporting the death of a husband. She makes being with her husband when he died relevant to her story.

IE can be seen here to be doing work on her experience so that it is heard in a particular way. She is producing it as a personal account of witnessing a death. This can be seen in relation to Sacks's (1992; LC2: 242-248) lecture on witness entitlement to experience, which was referred to in Section 4.2 above (page 99). He discusses the data extract reproduced below where a woman reports on an accident she has seen while driving past in her car.

Extract 4.3 (Sacks, 1992; LC2: 241)

1 A: Say did you see anything in the paper last night or hear anything
2 on the local radio, Ruth Henderson and I drove down to Ventura
3 Yesterday
4 B: Mm hm
5 A: and on the way home we saw the: : most gosh awful wreck.
6 B: Oh: : : :
7 A: - we have ev – I've ever seen. I've never seen a car smashed into
8 sm – such a small space.
9 B: Oh: : : :

Sacks comments that having witnessed the accident she has become entitled to it, but that entitlement to reporting on experience is organisationally bounded.

> ...experiences...are extraordinarily carefully regulated sorts of things. The occasions of entitlement to have them are carefully regulated, and then the experience you're entitled to have on an occasion you're entitled to have one is further carefully regulated. And, insofar as part of the experience involves telling about it, then that's one of the ways in which you lay yourself open to having, eg., made too much of it, experienced it wrongly, not seen the thing you should have seen, etc (1992; LC2: 248)

In Extract 4.2 IE carefully regulates the experience of witnessing a death. First of all, unlike the woman in Sacks's example, IE reports that she was grateful for the experience. IE also sets up her entitlement to certain feelings given this particular experience. This marks it up as a personal experience, demonstrating her relationship with the materials she is reporting on and her entitlement to report in different ways depending on her type of experience[70]. She sets up talking about emotions as something that is accountable[71].

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[70]Gubrium and Holstein (1997) describe how emotionalist researchers are concerned to close the gap between subjectivity and public data. Here IE accounts for this gap, making a distinction between her own subjective experience using 'I' and societal experience using 'it'.

[71] Edwards (2001) describes how: 'Emotional states may figure as things to be *accounted* for (in terms of prior causal events or dispositional tendencies, say), as *accounts* (of subsequent actions and events), and also as evidence of what *kind of events or actions* precede or follow them' (p236).

Saying that you are grateful for this infers that this is part of something in which IE is personally involved. It would be odd for someone to say they were grateful for this type of experience generally. It is not usually acceptable to be grateful that people die, which would be one possible implication for saying that you were grateful for being with someone when they died. Therefore the recipient hears it as situated within a wider context of people dying. In relation to Sacks's discussion of the woman who witnessed a car wreck in Extract 4.3, that witness would not be entitled to be grateful for that experience, as it would imply that she was pleased that the wreck had happened and this would have negative social connotations. Here IE sets it up as appropriate that she was grateful given the circumstances. In doing so IE also draws upon the husband-wife SRP that she sets up by saying 'I was with him when he died'. Saying she was 'grateful' for this is partly about being a spouse, going through events like this together. The circumstances are the personal nature of the experience set up in this extract, and also the course-of-action nature of the story that is invoked through her providing no additional explanation of why she was in this particular situation.

The way in which experiences are carefully regulated, as Sacks suggests, can be seen in relation to this description in that IE constructs both a personal and societal experience with associated feelings. She provides two types of assessment, one for her feelings (fear), and one for how the event may be generally perceived (harrowing). She demonstrates awareness of general social norms (death is harrowing), and personal emotional responses (death can be frightening). She sets up her entitlement to report on these two levels of experience, as someone close to the person who is dying, and as a member of society.

IE binds the category death with the perception that it is harrowing. She also binds the category death to what she expected her own personal emotional response to be, i.e. fear (line 2). This is clearly identified as a personal response by the use of 'I'. She constitutes death as an event she would be entitled to experience as harrowing as a member of wider society. In this case she provides an assessment of the level of

'harrowing' that she experienced, i.e. it was not 'that' harrowing. In sum, IE makes two assessments here in relation to her experience of death. She uses harrowing to constitute death as general (i.e. as experienced by others in the category 'society') and fear to constitute it as personal to her. She invokes her identity as member of both the categories 'married couple' and 'society'.

IE sets up an entitlement to certain feelings associated with being with her husband when he died. She is entitled to this experience, and implies that she expected to experience a certain emotion, fear. She then says she did not experience fear at all - she was not frightened of being with her husband when he died. By using 'even' she implies that there are other possible ways in which she could have responded. Using 'even' works to produce an economical account. She only provides one example of a possible emotion here indicating that this is the minimum one would expect, to be frightened of seeing someone die. In this sense then, 'even' also works to set up the expectation that fear would be associated with death.

By not explaining why she should experience it as frightening, or why it could have been generally viewed as harrowing, she implies that this is a generally accepted social norm. She is not going against the social norm that death is harrowing, but states that the intensity of it is conditional on certain factors. Death being 'harrowing' is associated with her husband being in pain – 'as long as he wasn't in pain'. She ties this general social norm about death (that it is perceived to be harrowing) to her personal experience. It would be harrowing for anyone, including her being with someone who died in pain. We can hear from this too that her husband was not in pain as this was a condition of the death not being 'that' harrowing. She is not saying that it was not harrowing at all. If she did, she could be heard as being cold or impersonal. Her assessment is tied to this condition. The comment about pain is presented as reported speech, 'I said…', which indicates that she had talked about it to the health professionals. This sets her up as someone who is able to express their views and who is responsive to the obligations of the husband and wife SRP. However, although she says 'I said' she does not use direct

reported speech[72]. She makes it a general comment 'I said as long as he wasn't in pain'. We hear that IE is satisfied with the health professionals involved in this event in two ways. In lines 1 to 3, IE does not make any criticism of the health professionals. In lines 4 to 7 she praises them.

After her description of the experience of being with her husband when he died, there is a gap of 0.8 seconds before she speaks again. This is a relatively long gap and could be heard as an opportunity for IR to take a turn. In everyday conversation Pomerantz (1984) proposes a speaker's procedural rule regarding assessments, that recipients of initial assessments commonly attended to assessments by proffering their own assessment of the 'referent':

> In proffering an initial assessment, a speaker formulates the assessment so as to accomplish an action or multiple actions, for example, praise, complain, compliment, insult, brag, self-deprecate. In the next turn to the initial proffering, an action by the recipient is relevant: to agree or disagree with the prior. (p63)

It is therefore of note that IR does not take the opportunity to make an assessment here, or to show 'alignment' with the speaker (Jones, 2001). Unlike Pomerantz's data, such an action by IR (proffering an assessment) does not become relevant. The absence of an assessment by IR here appears to mark the assessment work IE undertakes in her description of her husband's actual death as a delicate topic. If IR had come in here, or IE rushed onto a new topic it could potentially be heard as disrespectful. The absence of a second assessment is relevant to the local context produced in the talk. This is a feature of institutional talk[73].

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[72] It is of note that IE's use of reported speech here is not the same as using 'direct reported speech'. It was seen in Chapter Three how direct reported speech is used at times to set up criticisms of health professionals. The use of direct speech in assessment work will also be further discussed in relation to the data analysis in Chapter Five.

[73] The absence of second assessments from professionals has been observed in a number studies applying CA to institutional talk. For example, see Taylor (1999), Jones (2001).

Extract 4.4 (Interview 4 – part of Extract 4.2 above)

4 IE (0.8) and (0.2) they were very good (0.4) he died about 11 o'clock in the
5 morning (0.5) lovely girl on (.) 23 years old on her own (.) my God I
6 couldn't have done that (0.2) nothing like that at 23 myself (0.7) very nice
7 (.) nurse

IE links this piece of description with the immediately preceding talk by saying 'and', which indicates that she is shifting to a related but separate topic. If she had said 'because' this would tie events in the immediately previous talk to what she says here. If she had said 'then', it would signal a new event happening. Following 'and', IE provides an assessment 'they were very good'. This can be heard as referring to the hospital staff. In using the conjunctive 'and', IE indicates that what follows is to be heard as influencing her experience of being with her husband when he died as positive. She has already described a condition, her husband being pain-free. This can be heard as a necessary condition by her use of 'as long as'. In using 'and' after her description of the death of her husband in lines 1 to 3, IE implies that the assessment which follows, 'they were very good', is an additional factor contributing to it being a positive one.

The report, 'he died at 11 o'clock', adds detail to her description indicating that she remembers the events well. This provides support for her assessments of the hospital staff. If she can remember specific details like time, then her assessments are also likely to be reliable. IE does not state directly what she means by 'they were very good'. However, after making this general assessment about the hospital staff, she singles out someone, 'lovely girl', for particular praise. She does not identify the 'lovely girl' as a nurse at first. However, when IR does not acknowledge her assessment after the 0.8 second gap on line 6 she makes a second assessment of this person, this time identifying the 'lovely girl' as a nurse.

4.4.2 Lay and professional identity work – Collection K

IE invokes Collection K here, distinguishing between lay and professional roles, in that she says that the 'lovely girl' was on her own. We know, however, that in a concrete sense she wasn't on her own as IE and her husband were there. This infers that IE is

categorising her as a professional. As well as the nurse being 'lovely' and 'very nice', IE constitutes her as someone remarkable or special, by associating qualities with her that she does not have herself. IE provides an assessment about her own abilities 'couldn't have done that', which has implications for how the nurse should be viewed. This assessment is prefaced by 'my God', which marks up the actions of the nurse as remarkable. She is not saying that she is inadequate for not being able to do it, rather the nurse is remarkable because she can. It is qualified further by IE saying she couldn't have done anything like that (not just that) herself at such a young age. In this way this nurse is constituted as special. She sums up the description of which she started with 'they were very good', with 'very nice nurse' at the end of the extract (line 7). Again IE provides an indicator of the reliability of her assessments, through stating the specific age of the nurse. She has observed and remembered this detail. However, she does not provide too much detail.

The use of detail is carefully selected to characterise a scene (Sacks, 1992). Sacks comments that it may be best not to use too much precision as it raised issues for both the speaker and recipient regarding the relevance and reliability of the detail presented. In reference to the description of the car accident in Extract 4.3 above, Sacks comments that '...by virtue of the fact that the other is figuring out what you're telling them, they will have been required to also employ such sorts of information such that they can see that you're possibly competent at observing wrecks' (p235). This is similar here as in stating the age of the nurse the recipient has to employ information about age and experiences of events like death. In using the detail of the age IE shows that she knows how to describe an event such as being with someone when they die, and has possibly correctly characterised it. Using more detail raises questions for the recipient about the reliability of the information, and consequently may make the description equivocal[74]. This is also of note in the way she remarks on the time of death on line 4.

[74] Sacks comments that: 'Instead what one does is offer the product of what can be seen to have been specifically done as an educated analysis, and thereby be seen to have been done by someone who knows how to look – if it's told to someone who knows how to hear. So that this possible 'vagueness' of the report – "quite a while," well how long was it? – is not a defective kind of vagueness but is the way to show that you measured the thing in an appropriate way to measure, e.g., being caught in a traffic jam'. (1992; LC2: 236).

It is interesting that, whilst IE has demonstrated her entitlement to death as a personal experience in lines 1 to 3, she regulates her entitlement to experience as Sacks suggests, by stating that she does not fulfil the criteria for being entitled to experience being with someone who died in a professional capacity. She sets up this denial of entitlement by saying she could not have done what the nurse did. By constituting the nurse as special, she in effect sets up a condition for being with someone who died in a non-personal way. This further constitutes her experience as a personal one as it can be seen in relation to her lack of entitlement to a non-personal experience of this type, in that she says she could not do it.

The assessments in lines 4 to 6 are used to praise the hospital staff. However, IE is non-specific about what the staff did that was very good, or even why the 'lovely nurse' was lovely. The praise assessment work is however category-bound, in that the staff being good, and the nurse being lovely are related to the assessment work in lines 1-3 where IE can be seen to describe her husband's death as a positive experience or a 'good death' (given the circumstances)[75].

4.4.3 Summary of Extract 4.2

In this extract the speaker sets up her entitlement to describe certain experiences. This is done prior to making the assessments. She distinguishes between her personal experience of the death (as someone who has a close relationship with the person who died), and a broader societal experience of death. In doing so she sets up boundaries to the entitlement to comment on such experiences. Her own 'personal' experience is not automatically available for assessment. IE also does identity work, distinguishing between lay and professional roles and expected responses by both herself and the health professionals, associated with the experience of being with someone who has died. Her description also works to praise the health professionals providing care for her and her husband.

[75] The notion of the 'good death' is discussed in a number of papers and texts on death and dying. For example, see Young and Cullen, 1996.

4.5 Discussion

A more detailed discussion of assessment work in interview accounts will be included in Chapter Five. However, I will briefly consider the way in which the analysis of Extract 4.2 contributes to the study of subjective experience, previously discussed in relation to the emotionalist research idiom discussed in Chapter One. Emotionalist sociologists aim to describe social life on a level that includes subjective experience. Such 'depths of experience' are said to pose a major challenge to qualitative method (Gubrium and Holstein, 1997: 57). Ethnomethodologists are held to be particularly distanced from the study of subjective experience, 'with little or nothing to say, by self-imposed definition, about the experiences that concern human beings the most in their everyday lives' (Douglas, 1977: p10-11). Let us briefly consider Douglas's point in relation to the analysis presented here.

The analysis of assessment work in Extract 4.2 elucidates how emotional concerns may be raised and described in an interview account. A sociological description has been produced of an account of the death of a spouse. A central feature of the speaker's account is her emotional experience during the death itself. The speaker constructs a personal or subjective experience in relation to a societal experience. She makes emotion talk an accountable issue, distinguishing between certain types of experience, and setting up entitlements to describe them. This demonstrates the value of examining emotion discourse in use, so that observations can be made regarding how it provides a sense of events, states of mind, and as shown here, to manage issues of accountability (cf Edwards, 2001). Emotions can be studied through examining the practices members use to produce descriptions and attending to the issues they make relevant in their accounts. The explication of this work on emotions is therefore a form of by-product of the analysis of assessments[76].

[76] Allen (2000) argues that there is a need for more sociological research on 'the ways in which emotions shape negotiations in the health care context and indeed, how emotions may themselves be subject to negotiation' (p167). Allen's research was undertaken in a clinical setting. However, given the increasing use of qualitative interview studies in the evaluation of health care and the availability of this data, such analysis of the production of emotion in interview accounts may contribute additional and complementary insights into the negotiation of emotion in terms of how they are produced in accounts describing health care experiences.

It was mentioned earlier (Section 4.1.1 and 4.3) that assessments are examined as part of the machinery that produces occurrences. The previous chapter documented some of the work that goes into producing criticisms of health professionals. However, the focus of analysis was on criticism rather than the machinery that might produce it. This chapter shows how the analysis of assessment work has produced praise (and emotion talk) as a by-product in the way Sacks describes (see page 104).

The relationship between the machinery that produces occurrences, or assessment work, is not immediately obvious. However, the occurrences themselves are relatively easily recognised by both members and analysts. Consequently in much qualitative interview research topics in the talk such as praise or emotion talk may be identified and analysis undertaken at that level[77]. Such analyses are often said to describe issues that are important to interviewees regarding a particular topic. However, examining the machinery that is used to construct experiences reveals a range of other activities in the talk that are not readily observable to the lay person. This is discussed by Schegloff in relation to Sacks's work on the production of by-products in talk:

> In passing Sacks here produces an account of the perception of coincidences that makes of it not a mistaken commonsense notion of probability, but something like Marx's notion of alienation; that is, that persons' own activities (here the practices by which stories are formed up) produce a result (an account of activities that is designed to make for relevant-at-that-moment tellable stories), which is then perceived not as a product of the design of storytelling, but as an independently encountered – and somewhat mysterious - 'external' reality. (1992b; LC2: xxiv)

The activities undertaken in talk that produce things like praise and criticism are not necessarily set up as end-products. This was seen in Chapter Three where ambiguity

[77] A problem arises for the analyst in that it not possible to analyse all these by-products at the same time. Choices have to be made about what problems to investigate. The phenomenological 'bracketing' process needs to be pursued throughout the analysis. I therefore make a brief comment on praise and emotion talk, noting their presence as by-products, but do not pursue them further as research problems in this thesis.

was used at times in the production of criticisms. In those cases the criticism was a by-product of collaboration between IE and IR (for example, see Extract 3.3, page 72). The analysis presented in Chapter Five builds upon this analysis to add further insights into how assessment work is produced in interview accounts.

Analysis of assessment work in the interview accounts has been based on the ethnomethodological imperative of describing the machinery that produces occurrences. An elementary rule of sociological inquiry is 'the practice of formulating a description of how it is done and by whom' (Smith, 1974: 44). The value of such description is demonstrated here in the way that analysis of descriptive practices allows a range of additional activities to emerge, (including praise and emotion talk). These actions are embedded in the actions of participants in the talk, and made relevant by them. This will be examined further in the next chapter.

CHAPTER FIVE

ASSESSMENT WORK IN RESEARCH INTERVIEWS: CRITICISING HEALTH PROFESSIONALS

5.1 Introduction

This chapter extends the analysis of assessments carried out in Chapter Four. A data extract is examined in which the speaker makes assessments of specified health professionals (two nurses), health professionals in general, and himself. However, here the assessments of the health professionals cast their actions in a negative light, and are used to criticise rather than praise. Accountabilities are set up, including those of the interviewee, regarding the events described. The data extract has been expanded from a short (assessment) sequence that was initially identified as an example of assessment work. This occurs in lines 15-17 and has been highlighted in bold.

Extract 5.1 (Interview 1)

IR make some notes as well (.) [as well as tape recording it (.) I'd like you to (.) it
IE [yeah
IR The first question I'd like to ask is for you to tell me (.) the story of what happened if you wouldn't mind (0.4) just to kind of give me an idea (0.2) [and then I'll
IE [well
IR come onto more specific questions (0.2)

17 minutes into the tape. Story to this point: IE gets a call saying his wife has collapsed in the village. He goes to hospital with her in the ambulance. She is taken away to be examined. After an hour and a half he asks a nurse how she is. He is taken to her and she is sitting up looking well. A doctor says nothing untoward was found which IE thinks is odd (see Extract 3.3, page 72). She was well for a while but starts to become slow and tired. She is referred to a consultant who prescribes some patches which produced side effects. She is admitted to hospital and a tumour is diagnosed. Little information was given to IE by his wife or the doctors. Back at home IE finds blood on his wife's pillow and she is re-admitted, now having a 'massive tumour' on her chest. She went home for a month and then to a specialist hospital as an outpatient for radiotherapy. Before the course is completed she becomes very ill and dies. He describes the night before she died she was still at home. She was admitted to hospital as there was no doctor available at the local hospice. IE is called in urgently and he and his family see her in a side room on the ward where she talks to them .

1 IE (0.3) and about (0.7) half past six (0.3) two nurses came in she said 'you'll
2 all have to go out' (0.7) and I thought that was a bit odd and well course like
3 sheep we all went out (.) you know I should have told them to go (.) and get
4 lost (.) you know (0.5) and of course while (.) while we was out (.) god knows
5 what these two nurses did (0.3)
6 IR so did your wife say that you all had to get out or the nurses said that you [all
7 IE [no the
8 IE nurses said [my wife was incapable of talking=
9 IR [right
10 IE =right yes [I'm sorry ( )
11 IR [you know she (.) she ( ) was virtually unconscious [then
12 IE [yes] yes (0.5)
13 IE and I wanted to stay 'til the end but you know (0.4) after we'd been out for
14 about half an hour (0.4) my granddaughter came up she said 'you'd bett:er
15 come back' (0.6) so I says 'has she gone?' so she says 'yes' (1.0) **so why**
16 **those nurses did that I don't know I mean they (0.2) I thought that was**
17 **most er (0.2) unkind of em** (0.6) but I I didn't complain you know (0.2) you
18 know don't wanna (.) nurses are in trouble as it is now without er (0.6) giving
19 em more trou[ble
20 IR [mmh] (0.6) well in so[me yeah
21 IE [but in er] you know (0.3) the lack of
22 information amazed me (0.7)
23 IR mmh=
24 IE =because er you know (0.8) (coughs) I'm not trying to (0.2) make meself up
25 as a saint but (0.2) you know I struggled to (.) look after my wife for quite a
26 long time (0.5)
27 IR mmh (0.2)
28 IE and I lost a lot of weight (0.7)
29 IR yeah (.)
30 IE and er you know (0.5) me mental capacity seemed to disappear as well (0.5)
31 cause normally I'm one of tho:se strict ones you know (0.2) [right is right]
32 IR [mmh]
33 IE (0.2) you know (0.6) but that (.) that that is er (0.6) most of it you know (0.2)
34 in a nutshell (0.5) the lack of information that was given to people =

I started to consider the highlighted assessment sequence in terms of the work that was going on in it, but found it was necessary to look back at earlier talk in order to understand the work that the participants, in particular IE, are doing here. The analysis was therefore extended to other surrounding talk that is closely tied to the activities conducted in lines 15-17[78]. Analysis of the extended extract examines how the participants, in particular the interviewee, carry out a number of different, but related, actions in this talk which are seen to demonstrate Sacks's point:

> There's a specific substantive problem which, stated kind of generally, has to do with conversation as a vehicle for problem solving, and there's another, more methodological problem which has to do with collecting observables and putting them into some such relationship as permits posing and solving problems with them. (1992; LC2: 384)

The talk on lines 6-12 is a query initiated by IR, and once it is attended to does not interfere with the story being told by IE[79]. This query sequence is not directly related to the analysis of assessments here so is not analysed.

By examining talk outside the assessment sequence itself this analysis closely examines how the assessment on lines 15-17 is produced and the work it does beyond the small activity system described by Goodwin and Goodwin. The extract examined is relatively long and has been separated into a number of segments for the purposes of analysis and presentation. However, given that the assessment work associated with the assessment sequence in lines 15-17 of the long extract is embedded in the whole of this extract, there is overlap. This means that although segments are presented separately in order to

[78] Goodwin and Goodwin (1992) comment that once an 'assessment segment' is identified the analyst can look in detail at the different types of action that co-occur with the event but that also precede and follow it. The disinctiveness and salience of assessment segments is also attended to by the participants.
[79]This is an 'insertion sequence' (Schegloff, 1972: 114). It will be seen in Chapters Six and Seven how the interviews follow a question-answer format. Insertion sequences may be used at times within this format, and interrupt, but do not disrupt the question-answer sequence. This is the case here. IE is providing a response to IR's initial request for the 'story of what happened' which can be seen on line 3 of the opening sequence. The query sequence initiated by IR does not disrupt the main question-answer format. This is demonstrated in the way IE takes up his story again in line 15. Insertion sequences are found in the opening turns of the interviews and are examined in Chapter Seven.

explore work done in particular places in the extract, I will also refer to other parts of the extract where it is relevant to the analysis.

I will start my examination of the extract by looking at the segment initially identified as an example of assessment work. I will then broaden out the analysis to look at the talk that precedes and follows it, in order to explore how it is produced and used by IE.

5.2 Setting up an assessment

Extract 5.2 (part of Extract 5.1 above)

15 so why
16 those nurses did that I don't know I mean they (0.2) I thought that was
17 most er (0.2) unkind of em

IE makes an assessment in lines 16 and 17, 'I thought that was most er (0.2) unkind of em'. How is this assessment set up, and to what does it refer? IE raises an issue using a 'so-preface' (Rapley, 2001b: 171) to relate the talk that follows to what has gone before. 'So' is used as a form of linking device. It both separates and connects descriptions. It has a role in linking the assessment in lines 16 and 17 to whom it is directed at and what it is about ('those' nurses, and 'that')[80]. It means that the utterance that immediately follows is part of a larger course of action (Rapley, 2001b).

After using the 'so' preface to introduce a new description, IE produces a preface to his assessment that the nurses are unkind, in the form of a reported query about the behaviour of some health professionals, 'why those nurses did that I don't know'. The first part of the assessment preface is presented in the form of a rhetorical question, 'why

[80] Rapley (2001b) found that so-prefaces in open-ended interview data are commonly used at the beginning of questions. They indicate that the interviewee is responsible for the topic of the question, rather than the interviewer. In addition, the interviewer is demonstrating through the use of the so-preface that they are doing following up, close listening, and being interested. In my data the interviewee is the one who is responsible for the topic, is asking the (rhetorical) question, and is the one who uses the so-preface. In this extract he is demonstrating that he is paying attention to the detail of his own story, and follows up points that he is making. In this way he is attending to recipient-design considerations. This data is discourse-unit talk (Mazeland and ten Have, 1998) and it appears that the responsibility for monitoring the story telling is with the interviewee.

those nurses did that'. The second part is an answer 'I don't know'. The preface is in the form of an 'adjacency pair', where two utterances placed next to each other are related (Sacks, 1992; LC2: 522)[81]. Here the two utterances are related as IE both sets and answers a question. In other circumstances asking a question would indicate that another person should answer. However, by asking a rhetorical question, IE sets himself up as the person who should answer. It also means that his answer is required. Without the second utterance, 'I don't know', the sentence is incomplete. 'Why those nurses did that' is not set up in the form that it is expected that someone else could answer.

5.3 Lay and professional identities

IE sets up both lay and professional identities in this extract. They are used as a key resource in assessing the actions of the health professionals. In identifying 'those' particular nurses, IE indicates that he is not querying the behaviour of all nurses, just these particular nurses. The hearer needs to identify to whom he is referring in order to understand the assessment. The hearer knows IE is referring to characters he has already mentioned as he does not provide any further details here as to who those nurses might be. In addition, IR does not ask to whom he is referring which indicates that she knows. He does not say what they did here, or in the immediately preceding few lines (though what happens in the previous few lines is related to the assessment).

In order to locate who those nurses were and what they did, the hearer must go back to earlier in the account to find out. By saying 'those' IE limits the search so that the hearer need only go back to the last place nurses were mentioned. This implies that the object of the assessment is nearby. As seen in Chapter Four, the object of an assessment is referred to as an assessable (cf Goodwin and Goodwin). Saying 'those' acts as a pointer to the assessable. The preface does the work of orienting the hearer to what the assessment is about, here directing the hearer to something he has talked about earlier, where he describes two nurses having asked him and other visitors to leave his wife (lines 1-5). There are two identifiably separate pieces of description (or topics

[81] Adjacency pairs will discussed in more detail in Chapter Seven. The adjacency of two utterances does not automatically mean that they will be related but it does provide for the possibility that they might be.

discussed) between that on lines 1-5 and this one, so IE must provide a preface here to locate his assessment, that the nurses were unkind, for the hearer.

5.4 Nurses' motives (assessments and motive)

In saying 'those nurses did that', IE reports that particular nurses performed an action of some sort. He sets up an event or action ('did that') by some nurses ('those nurses'). He then queries this action, saying 'why?' followed by his answer 'I don't know'. He sets up the nurses as having a motive for acting in this way. Motives are the terms with which people interpret the conduct of themselves and others:

> Motives are imputed or avowed as answers to questions interrupting acts or programs. Motives are words. Generically to what do they refer? They do not denote any elements "in" individuals. They stand for anticipated situational consequences of questioned conduct. Intention or purpose (stated as a "program") *is* awareness of anticipated consequence; motives are names for consequential situations, and surrogates for actions leading to them. Behind questions are possible alternative actions with their terminal consequences. (Mills, 1972: 441)

Here we can see that IE raises the issue of the nurses' motive in order to interpret their behaviour in this situation. In saying 'why', he proposes that there is a reason for their actions, though he reports that he does not know what it is. His question suggests that there were possible alternative actions available to the nurses, which sets them up as making a choice and therefore acting rationally. Saying he does not know why they acted as they did keeps open the possibility that there may be a reason he is unaware of as a lay person. However he offers no suggestions for appropriate alternative actions, such as special nursing tasks. The nurses are constituted as 'theoretic' actors (McHugh, 1970: 62) who can be said to have intended to do what they did. Imputed intentions are a central feature in deciding on the character of an act (McHugh). The nurses can therefore be treated as agents of their own behaviour and their act as a motivated act. As McHugh suggests, 'Someone who "knows what he's doing" in this special sense will be held accountable for his acts and responsible for his behaviour' (p77)[82].

[82] There are similarities with the way in which motives are set up in criminal cases before charges are made.

It is the ascription of rationality to the nurses' behaviour that provides for the possibility of this particular assessment. Given the imputed motive, the nurses can be charged with being unkind and are held morally accountable for their behaviour. IE does not raise the possibility that these nurses are acting irrationally, or as 'pre-theoretic' actors. He does not let them 'off the hook', or suggest that their action is 'conventional'. He implies that they had choices available.

By contrast, the issue of the motive behind the behaviour of the health professionals is not queried in Extract 4.2 in Chapter Four (page 105), where IE praises their actions. This can be considered in relation to Mills's (1972) comment that motive talk usually gets done when something fishy is reported, not otherwise.

The preface enables IE to make his assessment that the nurses were unkind, but does not interfere with his status as a lay member of Collection K. In setting up the preface and assessment in this way, IE is able to imply that the nurses must have known the possible outcome (that he would not be with his wife when she died). In this way he ascribes a negative motive to the nurses' behaviour. If the nurses had acted unwittingly, that is without being aware of the possible effect of their behaviour, IE would not have been able to make his assessment that the nurses were unkind as it is unreasonable to criticise the behaviour of people who did not know the likely result of their actions.

5.5 Criticism (of health professionals)

The assessment work is used to do criticism on a number of levels. In this way the criticism has a number of features which are set up through the assessment work:

- The nurses were unkind
- The actions of the nurses were unkind
- No reason was given for the actions of the nurses

The implication that the nurses were unkind is relatively straightforward. The preface directs the recipient to what the nurses last did, so we can see that they asked him and his family to leave her bedside. He is referring to this directly as an unkind act. The way in which the other two features of criticism are set up and achieved is more complex. These features will be examined below.

5.5.1 The nurses' actions

What the nurses did, or 'that' (line 16) is part of the assessment. This is what the assessment is about. He is not making an assessment of them personally in the sense that they are bad people rather he is making an assessment of their actions. In this instance, motive is constituted as a feature of the actions of individuals, rather than the individuals themselves. However, the individuals are held accountable for those actions.

What did the nurses do which was unkind? They did two things. The first was that they asked him to leave his wife's bedside. The second and more important action is that they prevented him from being with his wife 'til the end' (line 13), which is something that he wanted. IE constitutes this as important. The result of asking him to leave was that he was not with his wife when she died. This is something that 'those nurses' were the cause of. Whereas asking a relative to leave someone for a short while may be acceptable (though it was not acceptable for IE given that his wife was so ill), not allowing a husband to be with his wife when she dies is unacceptable. This can be compared with Extract 4.2 in Chapter Four, where IE expresses her gratitude for being with her husband when he died and praises the health professionals, singling out one nurse for particular praise. Here IE singles out two nurses for criticism. The criticism is tied to his entitlement to be with his wife when she died.

5.5.2 Entitlement to be with a spouse when they die

Members mention that there are constraints on entitlement to experience, knowledge and opinion (Sacks, 1992; LC2: 15). Producing assessments can involve establishing such constraints. This was seen in Chapter Four, where the interviewee sets up an entitlement to report on a personal experience. In this extract IE establishes an entitlement to be

with his wife when she died. He constructs this carefully over the course of this extract even though he was not actually present at the death. Particular care needed to go into constructing this entitlement as he did not take it up. He therefore has to do a lot of work explaining why he did not do so. Being unable to be with his wife when she died is constructed as a criticism of particular health professionals. This negative experience can again be compared with Extract 4.2 in Chapter Four, where IE describes being with her husband when he died as a good thing. IE constitutes not being allowed to stay with his wife as a denial of his entitlement. However, he also acknowledges that he had a part to play in asserting this right, and gives reasons for not doing so in the form of a number of extenuating circumstances, which will be explored shortly in Section 5.10 below. It is not enough to be entitled to something you have to make sure that you get what you are entitled to (if you are going to raise it as an issue).

It can be seen that the statement 'why those nurses did that I don't know' (lines 15 and 16) does a lot of work in relation to this implied criticism. It works to direct the hearer to the assessable. However, this preface cannot alone adequately explain what the assessment is about. Some assessment formats are complete with a preface immediately followed by an assessment. For example, it can be seen in the fragment below taken from Extract 4.2 in the previous chapter that the assessment 'I was very grateful' refers to being with her husband when he died.

Extract 5.3 (part of Extract 4.2, Chapter Four)

1 I was with him (0.5) when he died (0.8) whi:ch (0.2) I was very grateful (.)

In the assessment sequence in lines 15-17 above, IE invokes the course-of-action device. The events described in this extract can be heard as part of a longer story, and the hearer must make sense of the assessment by referring back to earlier activities described by IE. This is indicated in a number of ways. In order to understand what the assessment is about in lines 15-17, IE directs the hearer back to the last time he mentioned 'those' nurses. This makes the talk that immediately precedes the assessment relevant. It is in

this piece of description that we hear that IE's wife has died and come to know that he was not with her when she did.

5.5.3 Not being given a reason (by the nurses for their actions)

IE's description of not being given a reason for the nurses' behaviour, 'why those nurses did that I don't know', also implies a criticism of the nurses. He does not raise his unanswered question here just as a preface to his assessment, he makes it relevant to the ongoing assessment work he is doing. The 'not knowing' here can be heard as an illustration of what he means by 'lack of information' (from health professionals) which is referred to again later in the full extract (lines 21-22, and line 34).

Sacks (1992; LC1: 33) comments that the answer 'I don't know' to the question 'why', as reported here, is a 'sort of deeper answer; that is, it might have an awareness of the character of this knowledge as something only professionals have'. Reports like this are instances that are marked up as absences of information from professionals. IE does this at a number of points throughout his interview account. To make a case for a criticism about not being given information by health professionals, IE would need to provide evidence. The description on lines 15-17 forms part of the evidence that contributes to the case for a final appraisal of his experience of his wife's death and illness, 'lack of information' on line 34. The assessment that the nurses were unkind has local relevance in that it is about a specific activity, asking him to leave his wife and preventing him being with her when she died. It is also relevant to constructing the account as a series of events that can be criticised, or an atrocity story[83]. IE produces instances throughout his account, which build a case for his summing up at the end of his story, 'lack of information' (line 34).

[83] Stimson and Webb (1975) found that patients describing their relationships with doctors commonly described them as 'atrocity stories'. This was also found by Baruch (1981; 1982) in his interviews with parents of children with medical conditions.

5.6 Entitlement to report an opinion

IE constitutes the assessment as a personal viewpoint or opinion. The notion of 'opinion' partly provides for professionals' talk to lay people, as they can express opinions without having to defend them (Sacks, 1992; LC1: 33). In this way it can be contrasted to professional knowledge. This can be seen here, where IE initially starts to present his comment as a report by saying 'they', indicating that he was about to say something like 'they were unkind'. However, he repairs this to 'I thought', producing 'they (0.2) I thought that was most er (0.2) unkind of em'[84]. This indicates that he is not entitled to report on what happened as knowledge. He takes responsibility for his observation as a lay person, which makes it an assessment or evaluation of the nurses' actions, rather than a report. Had he said 'the nurses were unkind' he would have attracted the charge that there may have been good reasons for the nurses' behaviour which he was unaware of, not being a professional. Saying they were unkind would require some defence or explanation. He is unable to provide this as he does not know the reason behind the nurses' behaviour. He therefore constitutes himself as a lay member of Collection K who is entitled to *opinions* about what happened rather than *knowledge* about it. IE adds emphasis to the assessment by saying 'most (unkind)'.

The listener is directed to something mentioned earlier in order to understand what he is referring to as 'unkind'. The information about the object of the assessment (those nurses) and the action being assessed (that) is contained in lines 1-5. The analysis will now be broadened out to examine how the assessable, i.e. what the nurses actually did that is the focus of the assessment in lines 15-17, is produced by IE.

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[84] The observation of the nurses' behaviour as unkind, which is expressed here as an opinion rather than knowledge, may also work to construct the talk as institutional interview talk. He may not have made the correction from 'they' to 'I thought' in a different situation such as conversation with friends or relatives.

Extract 5.4 (part of Extract 5.1 above)

1 IE (0.3) and about (0.7) half past six (0.3) two nurses came in she said 'you'll
2 all have to go out' (0.7) and I thought that was a bit odd and well course like
3 sheep we all went out (.) you know I should have told them to go (.) and get
4 lost (.) you know (0.5) and of course while (.) while we was out (.) god knows
5 what these two nurses did (0.3)

It can be seen on line 1 that 'two nurses' came in and 'she' told them to go out. As IE mentions no other nurses before making his assessment on lines 15-17, we can take it that it is these nurses he is referring to. Similarly, he mentions no other actions that the nurses did before lines 13-15, so we can take it that his assessment is based on these nurses telling him (and some others) to leave. IE's use of direct reported speech on lines 1 and 2 is in line with the analysis in Chapter Three where it was seen that it is commonly used as a resource in criticism and complaint sequences. He highlights the comment by a nurse, 'you'll all have to go out', as a problematic action. It is used to represent a transgression.

IR queries who it is that IE means on line 6 and IE states that 'she' means the nurses rather than his wife. IE reports what the nurse said as an order, 'you'll have to' rather than as a request. It would be reasonable to see this as unkind, i.e. ordering someone to leave the bedside of their dying spouse. An order provides no opportunity for reasonable refusal. To go against it would be to disobey the nurses, who know better. In this way he shows his reluctance at that time to question Collection K and its ordering of identities. IE does not say here that the nurses gave no reason for this behaviour, but raises the absence of an explanation in lines 16 and 17.

IE makes an assessment that he thought 'that' was 'a bit odd' (line 2). Despite the use of direct reported speech, saying a 'bit' odd makes the comment about the nurses telling him (and the others) to leave his wife's room cautious (see Chapter Three, Extract 3.3, page 72). 'That' can be taken to be the order to go out. He presents this as an opinion saying 'I thought' first. The use of 'I thought' here is similar to the way it is used on line 16 where IE presents his assessment as an opinion rather than as a report. As a lay

person he opts for opinion given the difficulties involved in challenging the knowledge and behaviour of health professionals. There may have been good reasons for the nurses telling IE and family and friends to leave. For example, they may have needed to give his wife some form of drug treatment.

It would be difficult to say 'it was odd' here without explaining what he meant. Nurses telling someone to go out while they attend to a patient would not be something that would generally be considered to be odd. The hearer needs some more information for it to make sense. He provides this, but over a course of events. IE uses 'I thought' to raise a possible doubt as to the validity of this action on the part of the nurses. IE marks it up as something to check later. If he had not done this, a charge could be made against him that, if he thought this was not appropriate behaviour at the time, why did he not do anything about it? On the other hand he deflects a possible charge of jumping to conclusions too quickly, and reports having deferred to the hierarchical power relationship between lay and professional members of Collection K. In this way he makes it clear that he is not a judgemental dope (see Chapter Three, page 70).

IE reports that he went out of his wife's room with some other people, 'we'. It can be taken that these other people are relatives or friends close to the patient, as it is unlikely that health professionals would ask other health professionals to leave[85]. IE produces an assessment, 'and well course like sheep we all went out' (lines 2-3). The 'and well course' links this report which includes the assessment 'like sheep', to the nurses' order to get out. They went out in response to the order from the health professionals. No-one in this lay group asserted themselves and requested to stay, or asked why they should leave. They responded as a group of people, like 'sheep', rather than individuals with differential rights and privileges. The use of 'sheep' implies a herd mentality, people not thinking about what they are doing as individuals. He did not think for himself at this time. The term is generally used to refer to people who will follow what others are doing. This is a critical assessment of his actions at the time.

[85] Also, it is commonsense knowledge, that unless stated otherwise, when someone is very ill the people likely to be at their bedside are relatives or friends.

IE later provides some explanation for his actions at this time, in particular that 'me mental capacity seemed to disappear' (line 30). He follows this with a self assessment that, 'normally I'm one of tho:se strict ones' (line 31), indicating that although he was like a sheep at that time, this is not his usual behaviour. There were extenuating circumstances, which caused him to act out of character. His description of the extenuating circumstances pertaining to his behaviour described in lines 1-5 will be examined shortly in the analysis of lines 24-33. Although this comes after 'I thought that was a bit odd', the implication here is that he was thinking it was a bit odd at the same time they were going out. IE produces himself as someone who reflects on what happens to him. He produces a balance between reflecting and making judgements with the limited evidence available to him.

5.7 A conflict in roles: lay-professional and lay-lay (category sets)

IE describes a situation where his wife is very ill and has him and other family and friends by her bedside. He invokes roles as a member of both Collections R and K. As part of Collection K, he did what the nurses said and went out of his wife's room. He (and the other visitors) responded to the nurses' demand. He indicates that this response was almost automatic, no questions asked, saying 'course'. The response to the nurses' order to go out is bound to their lay membership of Collection K. As a lay member of Collection K his role is to defer to the knowledge of the experts (health professionals). After describing them leaving, IE then proceeds to criticise himself for doing what the nurses said (lines 3-4). He invokes Collection R in which he has responsibilities and entitlements as part of the SRP husband and wife. He sets up a conflict between his roles as members of the two category collections. In this case, i.e. staying by the side of his sick wife, he constructs an entitlement to challenge the health professionals. Here he constitutes his role as member of Collection R as taking precedence over his role in Collection K. However, he did not do this and states what he should have done, 'I should have told them to go and get lost'. This is his assessment of the most appropriate action here. It is emphasised by the use of intersubjectivity, 'you know' before and after the assessment, implying that the recipient would hear this as the right (and

responsibility) of someone in this situation. He does not assert it as a right of the other lay people, just himself.

5.8 Online commentary

The way IE describes the actions of the lay and professional people involved in the scenario presented in lines 1-5 has similarities with Heritage and Stivers' (1999) analysis of doctor-patient consultations. They demonstrate how doctors resist prescribing antibiotics by doing 'online commentary' during the examination of the patient. Online commentary refers to the running commentary doctors make when examining patients, remarking on what they see and do not see[86]. Online comments take two primary formats:

(i) As reports of observations e.g. 'You can hardly feel the ovaries', 'I don't see any fluid'. `In the report format, the physician does not formulate an overt evaluation about the significance of an observation for the patient's health status, leaving it to the patient to draw their own conclusions.'

(ii) As assessments of what is observed e.g. 'Your ears look good', 'This one looks perfect'. `In the assessment format, conclusions are overtly drawn.' (Heritage and Stivers, 1999: 1503)

In one of the cases they discuss in detail, a distinction is made between a report, 'Well I don't see any fluid', and an assessment, 'your ears look good'. They remark that although the doctor indicates a disaffiliative action by the use of 'well', he/she more explicitly takes a position in the assessment. The comments by the doctor become more explicit, summative and cumulative. In using an assessment format for all the later comments the doctor sets up a position that is opposed to that which the patient has taken at the beginning of the consultation. By reporting each observation as it is made,

[86] Heritage and Stivers (1999: 1503) found that online comments could be divided into two types:

(i) Describes signs that are present but mild – takes the form of simple assertions, and normally uses terms that are mild, downgraded or qualified e.g. 'That's a little bit red back there'.

(i) Describes the absence of signs – this is often mitigated by the use of 'evidential' formulations e.g. 'I don't see any fluid'. These involve use of verbs like see, hear, and feel.

the physician progressively builds a more or less unanswerable case for the diagnostic conclusions she ultimately asserts (in this consultation).

The assessment work by doctors in Heritage and Stivers' data provides reassurance for patients. They do not need to talk while they examine. The interviewees in my data are required to talk (while providing the requested story). If we look at this in relation to Extract 5.4, IE makes reports which are followed by assessments as Heritage and Stivers describe in their data but the function of the assessments differs. IE describes the actions of two nurses and how he and his family responded. This sequence is followed by an utterance, 'while we was out (.) God knows what those nurses did' on lines 16-17. This can be seen as a form of online commentary on the respective actions of the lay people and professionals, as shown in Figure 5.1 below.

- nurses came in and said go out
- *thought that was a bit odd*
- we all went out (*like sheep*)
- *should have told them to get lost*
- while were out
- *god knows what the two nurses did*

Figure 5.1 – Using online commentary to describe lay and professional actions when asked to leave the room of a dying spouse

His description is similar to the physicians' online commentary described by Heritage and Stivers. It can be seen in Figure 5.1 that he uses it here as a resource that allows IE to relate the actions of the lay and professional people regarding the events he describes. He is able to account for his own actions, whilst at the same time implying that something was amiss with the actions of the professionals.

This is similar in structure to 'why those nurses did that I don't know' (lines 15 and 16). The implication noted here is that ordering someone to leave a very sick spouse and not give them an explanation is odd. At this stage it is 'odd' rather than 'unkind' as IE produces this assessment in relation to what he knew at the time. This assessment is used to make observations at this stage in the interview account, rather than evaluate.

IE implies that the nurses did something he is not happy with. This is indicated by his use of 'god knows'[87]. This utterance implies that there is something to criticise regarding what the nurses did, but IE does not say here what it is. It implies a cautious criticism, or a marker for the recipient as something of note that is relevant to the broader account. It again raises his concern with not being given information, as he does not know what the nurses did whilst he was out of the room.

IE needs to deal with IR's query in lines 6-12. However, he does not pick up his concern with what the nurses did immediately after this. First of all he describes how he found out that his wife has died.

Extract 5. 5 (Part of Extract 5.1 above)

13 and I wanted to stay 'til the end but you know (0.4) after we'd been out for
14 about half an hour (0.4) my granddaughter came up she said 'you'd bett:er
15 come back' (0.6) so I says 'has she gone?' so she says 'yes' (1.0) so why

IE describes how he came to know that his wife had died without having been told directly. He starts with the conjunctive 'and' followed by a report that IE wanted to stay 'til the end'. He describes it by reporting a number of related events: his granddaughter came up, she makes a statement (about what he should do), he asks a question and she answers it. His granddaughter does not say that his wife has died, but IE takes from her request that he go back (to his wife) that she may have died or 'gone'. He indicates that he heard 'you'd better come back' as a sign that his wife had died.

[87] This is an idiomatic expression. Drew and Holt (1988) found idioms to be commonly used in sequences where the speaker is complaining about personal difficulties.

5.9 Interviewer refraining from making an assessment

There is a long pause (one second) after IE reports that he heard his wife had died. This could be heard as a space for IR to come in, or as a turn transition point[88]. However, IR does not come in and waits for IE to resume his story. It was also observed in Extract 4.2 in the previous chapter that there was a gap of 0.8 seconds after IE describes her husband having died. It is usual in everyday conversation for a listener to respond to an utterance such as IE has made with a comment or second assessment (Pomerantz, 1984). The lack of a second assessment by the listener at this point indicates that IR is orienting to an institutional constraint on the talk. As Drew and Heritage comment:

> To the extent that the participants' talk is conducted within the constraints of a specialized turn-taking system, other systematic differences from ordinary conversation tend to emerge. These differences commonly involve specific *reductions* of the range of options and opportunities for action that are characteristic in conversation and they often involve *specializations* and *respecifications* of the interactional functions of the activities that remain. (1992: 26).

The absence of a second assessment by IR indicates that the interviewer is adopting a neutral stance. This is discussed further in Section 5.15 below.

By leaving the space here both participants mark it up as a delicate topic. This is similar to the gap after IE reports on the death of her spouse in Extract 4.2 (Chapter Four). It is treated as a respectful silence rather than a space for IR to come in, or for IE to continue straight away. If IE had not left a space at that point and rushed ahead to the next topic he may have been seen as uncaring. The space also indicates that IR knew that the death of IE's wife is part of the broader story. If she did not know, she would have been likely to express surprise, sympathy, or ask questions like what, when, how. The silence can be heard here as an appropriate silence in this piece of talk, constituting talking about the

[88] The notion of turns at talk is fundamental to CA. Turns are socially organised so that they are distributed among parties (Sacks et al., 1974). When significant gaps occur in conversation they can function as opportunities for another speaker to come in and take their turn.

death of a spouse as a delicate matter[89]. The space also marks up this activity description as finished, enabling him to move onto the next one, which he does by using the conjunction 'so' as a preface to his next utterance.

5.10 Not taking up an entitlement to make a complaint

Having discussed the relevance of some of the talk that precedes the assessment work done in lines 15-17, let us turn now to what follows and how it relates to the assessment about the nurses being unkind.

Extract 5.6 (part of Extract 5.1 above)

17 IE most er (0.2) unkind of em (0.6) but I I didn't complain you know (0.2) you
18 know don't wanna (.) nurses are in trouble as it is now without er (0.6) giving
19 em more trou[ble
20 IR [mmh] (0.6) well in so[me yeah

IE shifts to a new but related topic using the conjunction 'but' in line 17. The talk in this segment is about the possibility of making a complaint about the nurses he is referring to in the preceding talk and their behaviour. The report ('I didn't complain') and the assessment ('nurses are in trouble') contained in this segment provide for an additional implication of the assessment in the previous one, that IE had a right to complain. He does not say that this right was blocked in some way, which indicates that he considered that it was an option available to him if he wished to pursue it. He has already made a case for complaint in part, having established the precedence of Collection R over Collection K when a spouse is dying (lines 1-5) and the other criticism he does in this extract. Having set up this entitlement he has to explain why he did not take it up, i.e. why he let these unkind nurses off the hook.

IE sets up a reciprocal relationship between rights and responsibilities. Individuals may have rights, but they also have responsibilities associated with those rights. It can be

[89] This is mirrored in other social situations. For example, at football matches spectators and players are asked to observe a minute's silence if a player has died, or if there has been a disaster like Hillsborough. Participants do not just use actions like spaces in talk as general procedures, but make them interactionally relevant' (Sacks, 1992; LC2: 7).

seen from IE's actions here, that in situations where there are good grounds for complaint regarding the behaviour of others, and the speaker produces the evidence, then the complainant should take responsibility for not taking up this entitlement. A complaint is constituted by IE here as an action that would harm nurses. This means that although he does a lot of criticism, it is done within the context of the interview. Telling the people he is criticising about his views would constitute a complaint. He therefore criticises but does not complain. In this way he constitutes complaining as different from criticism.

IE also makes an assessment in line 18, 'nurses are in trouble as it is now'. This is given as a reason for not making a complaint about the two nurses he is unhappy with. In this assessment he generalises out from the 'two nurses' to all nurses. He infers that making a complaint about these two particular nurses would get nurses in general into trouble. IR does not add an agreement here, rather she makes a more ambivalent utterance 'mmh' followed by a short gap before she starts to make a comment 'well in some' before IE interrupts and cuts her off. This is a response to the maxim IE uses, 'nurses are in trouble as it is now'. IE uses the assessment that nurses are in trouble as a reason for not complaining. IR hears this as something that requires a response from her. However, her curtailed response is not an unconditional agreement. If she was going to agree completely she would have said 'yeah' or something similar.

5.11 Interviewer neutrality

IR's deviation from the pattern of these interviews is a display of neutrality. Displays of interviewer neutrality were observed by Clayman (1988) in his analysis of news interviews. He demonstrates how interview participants organise their interactions to display the neutrality of the interviewer. The interviewer was also seen to display her neutrality in line 15, when she refrains from making an assessment after IE reports hearing that his wife had died. In line 16 above, IE corrects himself from saying 'they...' to 'I thought they...'. The use of the preface, 'I think' here before stating an

opinion differs from Extract 4.2 in Chapter Four, where IE states opinions without using this type of preface: 'I said as long as he wasn't in pain (0.7) erm (0.8) and they were very good (0.4) he died about 11 o'clock in the morning (0.5) lovely girl on (.) 23 years old on her own'[90].

IE and IR actively adopt subjective and objective positions respectively vis-á-vis the interview. When it starts to go out of line, they both work to move it back on course. When IE makes a general subjective statement about nurses, rather than a personal subjective statement, IR is compelled to say something that will demonstrate her objective role as IR. IE picks up on this, interrupting with a general subjective assessment about his experience, 'the lack of information amazed me'. Cutting IR off in this way indicates that the response from IR is heard by IE as being in the 'dispreferred preface format' (Pomerantz, 1984). What his statement about lack of information refers to here is kept ambiguous. It can be heard as referring to the events he describes in the previous talk regarding his wife's death in hospital, or a more general view of contact with the hospital during his wife's illness. An important piece of work it does is to shift the focus of the account back to IE's subjective experience (from general comments about nurses). In making this general statement after talking specifically about 'those nurses' and then 'nurses', he also moves off the topic of complaints which he does not pursue further here.

Extract 5.7 (part of Extract 5.1 above)

21 IE [but in er] you know (0.3) the lack of
22 information amazed me (0.7)
23 IR Mmh=

[90] It appears that such prefaces may not be required when doing praise, but are when doing criticism. This implies that speakers are not required to adopt a defensive stance when doing praise but are when doing criticism. It has implications for consumer satisfaction research, as studies focusing on criticism are likely to yield more detailed data. Interestingly studies of satisfaction with health care are generally concerned with identifying dissatisfaction and view high levels of satisfaction problematic (see Chapter Nine).

Here IE moves on from cutting IR off when she starts to respond to his previous comment about nurses being in trouble. He starts to say something, 'but in er', but does not follow it through. He uses 'you know' to draw the interviewer back in and then makes an assessment, 'the lack of information amazed me'. This time IR provides a positive response token, 'mmh' after a gap of 0.7 seconds. As discussed above (in Section 5.5.2), a focus for IE's criticism of the nurses here is not being given information about being asked to leave his wife's bedside. In making a comment, 'the lack of information amazed me', IE moves the talk on from the specific, his case for complaint against the nurses and subsequent explanation of why he does not follow it up, to the general. He prevents IR from making a comment here as she tried to in line 20. It is harder to disagree or comment on a broad based personal comment. He reiterates his point about 'lack of information' at the end of the long extract, on line 34. However, before this he assesses his own actions in relation to the events he has described in this extract.

5.12 Managing lay accountability

IE assesses his own actions in this extract critically. This was seen in the way he describes going out of his wife's room 'like sheep'. He sets up both the actions of the professionals and the lay people as accountable. This is part of 'doing being reasonable'. It is not a one-sided account. However, he describes a number of extenuating circumstances that excuse his behaviour.

Extract 5.8 (part of Extract 5.1 above)

24 IE	=because er you know (0.8) (coughs) I'm not trying to (0.2) make meself up
25	as a saint but (0.2) you know I struggled to (.) look after my wife for quite a
26	long time (0.5)
27 IR	mmh (0.2)
28 IE	and I lost a lot of weight (0.7)
29 IR	yeah (.)
30 IE	and er you know (0.5) me mental capacity seemed to disappear as well (0.5)
31	cause normally I'm one of tho:se strict ones you know (0.2) [right is right]
32 IR	[mmh]
33 IE	(0.2) you know

In this segment IE assesses his own behaviour as a lay carer, and the effects of caring on his health. He ties this description to what immediately precedes it, a comment about 'the lack of information amazed me'. IE's use of 'because' on line 24 sets it up as an explanation as to what he means by criticising health professionals for not providing information. However, he does not do this by saying what type of information he expected, or what the consequences of this lack of information were. Rather he uses Collection K to demonstrate how the health professionals failed him. He describes his own 'lay' behaviour and its effect on his physical and mental state. In this way he shows that the health professionals are to be criticised for not fulfilling their roles (as givers of information), when he has fulfilled his role as lay carer. He does not criticise their care for his wife here, but the lack of information he was given.

IE makes an assessment on line 24, 'I'm not trying to make meself up as a saint'. This is a recipient-designed preface which is a pre-emptive strike against a possible charge that he could be unfairly comparing his behaviour with that of the nurses. He is not saying that he is a 'saint' or a special person. This would set up an unreasonable standard with which to assess the actions of others. It would be unreasonable to expect the nurses to be 'saints' (as saints are by definition uncommon)[91].

As seen in Chapter Three, making criticisms of others means that one's own behaviour is open to criticism. IE therefore states that his own behaviour was not perfect, indicating that he has scrutinised that as well as the behaviour of the health professionals. Again he is 'doing being reasonable', by establishing his own moral accountability. It adds emphasis to the criticism of the health professionals as he shows that he is willing to acknowledge his own faults, whereas the health professionals have not done this. Saying that he received no information from the nurses infers that they did not attempt to apologise or explain.

[91] An interesting comparison can be made here with Extract 4.2 in Chapter Four. In that extract IE bases her praise of the particular nurse on her being special, i.e. different from her. She does not call her a saint, but invokes a religious idiom, 'my God', when describing that she could not have done what the nurse did. However, in Extract 5.8 IE downplays his own behaviour as a carer to not 'saint-like', or not special. The way this type of categorisation work is set up in studies evaluating health care experience warrants further research.

IE differentiates between the morality of the health professionals' behaviour and himself. He states that his own behaviour can also be seen to be at fault, but he provides some extenuating circumstances in the form of a number of assessments that account for it. Whereas he can find reasons for his own behaviour he cannot for the health professionals, as they did not explain their actions. This can be seen in his assessment sequence about his lack of knowledge as to why the nurses were unkind (lines 16-17). The reference to lack of information from the health professionals in lines 21-22 is tied to IE's description of looking after his wife (at home).

IE's assessment of his experience, 'struggled' (line 25), indicates that caring for a sick spouse is not easy. He also states that he did it for quite a long time, after which IR provides a response token, 'mmh'. IE then provides some information about the effect of the caring on himself, 'lost a lot of weight'. This is followed by a gap of 0.7 seconds after which IR provides another response token, 'Yeah'[92]. That IE lost weight is used as evidence that caring for his wife was a struggle. It implies that he compromised his own personal care to care for his wife.

As well as describing the physical effects of caring, IE also describes a mental response. This is given as a reason for not being more assertive about staying with his wife when she died. The description of his mental state 'me mental capacity seemed to go' is less specific than his description of his physical state. Saying that it 'seemed to disappear' constitutes his recognition and description of his mental capacity as ambiguous. If he had omitted the 'seemed to', his account of events here could be heard as unreliable given that a lack of mental capacity would cast doubt on his ability to recall and describe events. This differs from his physical condition, where he is clear about losing weight. He ties the changes in his physical and mental condition together by saying 'as well' when talking about his mental capacity disappearing. He recognises his apparent lack of mental capacity by comparing his behaviour at one point in time with another, here his behaviour when caring for his wife with his normal behaviour. Not acting as he

[92] Saying 'Yeah' indicates that IR does not hear this as unusual. If she had been surprised she would have been likely to have said something like 'oh'.

normally would indicates to him that he did not have as much mental capacity as normal at that time, and therefore was not his normal self. IE proposes this as a possible solution to the problem of not being more assertive about staying at his wife's bedside when she was dying. The way in which he does this ties in with Sacks's discussion of problems people have where they do not have the ability to recognise solutions to such problems. He discusses this in relation to people with mental disturbance:

> ...there are kind of obvious ways in which that applies in some circumstances of people feeling suicidal or otherwise mentally disturbed, and it can be readily enough supposed that they might be in a position to not feel able to assess an offered solution and yet be concerned with its correctness (Sacks, 1992; LC2: 384).

It is also in line with McHugh's point about 'theoretic' actors, who are to be held accountable for their actions (see page 123). In line 31 IE describes his 'normal' behaviour. He sets up a standard, 'normal' against which he checks his behaviour. He also identifies himself as belonging to a particular category of person, 'those strict ones'. He then uses the idiom 'right is right' to illustrate what he means by 'strict'. The idiom 'right is right' (line 32) can be heard as a general moral rule, if something is right then it should be stuck to. It has been shown that earlier in the extract IE describes what he believes to have been right, that he should have been with his wife when she died and asserted this right as her husband. This is what he would normally have done. However, there were circumstances here which prevented him from acting normally, he was physically weak (he'd lost a lot of weight), and his mental capacity seemed to disappear. IE says 'you know' on line 33, after he says 'right is right', again indicating that IR will understand what he means by the idiom 'right is right'. IR provides a response token 'mmh' at the same time as IE says 'right is right', between the two 'you knows' indicating that she does understand what he means.

The detailed assessment work carried out by IE up to line 32 is summed up at the end when IE makes an overall assessment of his health care experience.

5.13 Summing up: producing an assessment in a story ending

Extract 5.9 (part of Extract 5.1 above) [93]

33 IE (0.2) you know (0.6) but that (.) that that is er (0.6) most of it you know (0.2)

34 in a nutshell (0.5) the lack of information that was given to people=

IE makes an assessment on line 34 'the lack of information that was given to people'. He has already made an assessment very similar to this one, 'the lack of information amazed me' (lines 21-22). However, here he uses the assessment to do different but related work, as a final summing up to end his story. He sets up his story ending by providing two utterances that work as prefaces. The first is 'that is er (0.6) most of it'. The second is 'in a nutshell'. Saying 'that' on line 33 refers to the whole story he has just recounted. We hear it this way for a number of reasons. IE has closed off the previous topic with the 'you know' at the beginning of line 33, which is followed by a gap of 0.6 seconds. He then starts a new topic with a conjunctive, 'but'. In having closed off the previous piece of description, IE indicates 'that' is not to be heard as referring just to his immediately preceding description (about his mental capacity having disappeared). It refers to the story as a whole, producing a closing or ending for the story.

5.13.1 Helping the interviewer by summarising

Prior to giving his assessment, IE uses 'you know' on line 33 after he has said 'that is most of it' (the first 'you know' is tied to the previous report about his mental state on line 32). He draws upon the intersubjective relationship between speaker and recipient, referring IR to what she has already heard. IR should know that that is most of it because she has heard the story. In saying 'that is er (0.6) most of it you know (0.2) in a nutshell' IE explicitly states that he has been selective about what to include in the story. He uses the analogy 'nutshell' to imply that this is very much a summary of the events that occurred. It also provides IR with the opportunity to ask questions if she wishes to hear more – this is presented as a particular (selected) version.

[93] This extract comes at the end of IE's story of his wife's death.

The statement 'that is er (0.6) most of it you know (0.2) in a nutshell' is also used as a preface to the assessment that follows, 'the lack of information that was given to people'. It performs two functions, to demonstrate that this is the end of the story and to provide an assessable for his assessment about the lack of information. Here the assessable is the 'that' on line 33, the story itself. Assessments are characteristic activities used 'to exit from larger sequential units in talk such as stories and topics' (Goodwin and Goodwin, 1992: 170). The story is summed up in an overall summative assessment. However, this assessment shifts context from the story he has just told, i.e. his own experience of health care, to 'people'. Here 'people' can be heard as lay people, with the information being not given by health professionals. He therefore invokes Collection K, creating a division between lay people and professionals. He indicates that his experience is representative of the experience of other lay people. Although he presents an account of a personal experience, it is at the same time similar to the experiences of others. IE's use of the category 'people' here demonstrates that he is like other people, i.e. 'ordinary'. He can be seen to attend to the business of being an 'ordinary person' which includes the business of '... attending the world, yourself, others, objects, so as to see how it is that it's a usual scene' (Sacks, 1992; LC2: 218). IE sums up by relating his experience to that of other people.

An additional implication of the final assessment, 'the lack of information that was given to people', is that the account is designed for an audience beyond the interviewer. He implies a meaning beyond the small activity system of the interview. To quote Sacks again:

> ...it turns out to be the business of *speakers* in producing an utterance, to attend not merely its consequences in terms of how it affects the person they're addressing it to, but also attend to how it affects others.... It's plain that parties design their utterances not merely by reference to who is receiving something they're doing, but what it's doing to third parties. (Sacks, 1992; LC2: 278)

The information has to be given by some people to other people. He recognises that IR will be writing a report both about, and for, a wider audience, not just about and for him. By saying that 'people' aren't given information implies that there are those who should

be given information and those who give it out. Though this is somewhat ambiguous, by not specifying otherwise IE's implication is that he means that there was a lack of information from people qualified (in a general rather than specific sense) to give it, i.e. professionals. By using the preface 'in a nutshell', the implication is that what is meant by 'lack of information' has been illustrated at earlier stages in the account and that this is a summing up. He is also careful to avoid being charged with having missed out some information, saying 'most of it' rather than 'that's it'.

The assessment 'the lack of information that was given to people' is also heard as part of a closing sequence by IR who comes straight in after he makes it[94]. There are three utterances here which form part of the assessment: 'that's most of it' directs the hearer to what IE has been recounting; 'in a nutshell' directs the hearer to his summing up; and 'lack of information' is the summing up. Saying 'in a nutshell' means that IE does not have to provide an explanatory description after 'lack of information'. However, it could be heard as a pre-closing invitation, i.e. a summary which a listener would ask someone to expand on.

5.14 Summary of Extract 5.1

The analysis of this data extract centred on an assessment sequence that criticises the behaviour of some health professionals ('those nurses'). The interviewee uses a number of resources to do the assessment and produce his criticism. He sets up a number of entitlements at different stages in this extract, which enable him to do the assessment work. These are entitlements to being with a spouse when they die, opinion, and to make a complaint. Setting up relationships between lay and professional roles and responsibilities (through category collections R and K) is crucial to his identification of the nurses' actions as unkind. It enables him to make a strong case for being with his wife when she died, and consequently for criticising the nurses he identifies as

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[94] The following lines follow directly from line 34 in Extract 5.9 (and 5.1).

35 IR =mmh (0.4) well (0.6) this (.) see this is the sort of thing (.) this is partly why
36 we're doing this study I'm in fact (.) I I've got the general picture which has
37 set the scene (0.2) and then I'm going to ask more specific questions

preventing him from doing so. He establishes their actions as intentional, but related to this criticises them (and the health professionals in general) for not informing him what was going on. His assessment of the appropriateness of the actions of the health professionals extends to his own behaviour (and that of his family). However, he presents a number of extenuating circumstances that explain his own actions. This is necessary, as having established an entitlement to be with his wife when she died, he has to explain why he did not take it up. The assessment work in this extract is also seen to contribute to a body of evidence for 'lack of information' which is the summary assessment made by IE at the end of the story.

5.15 Discussion

Within ethnomethodology the identification and use of assessments as a resource in talk-in-interaction has been the focus of a number of CA studies. This work includes analysis of the use of assessments in everyday and institutional talk. An alternative examination of members' categorisation work in setting up and using assessments in interview data is offered here. This section will consider how my analysis contributes to understandings of how assessments are set up and used in the interview data. It will be discussed in relation to studies that focus on the sequential way in which assessments are set up and used.

5.15.1 Assessments and assessment work

Assessment is evident in two forms in the interview data. Assessments are produced as phrases that are related to an assessable, for example, 'lovely girl' (Extract 4.2, page 105), 'I struggled to (.) look after my wife' (Extract 5.1, page 118). These phrases may also be part of larger assessment projects that the speakers are engaged in. Goodwin and Goodwin highlight the way in which assessments may be used as resources to produce an immediate local meaning, e.g. 'beautiful Irish setter', and also to contribute to assessment work that goes beyond the small activity system, or turn, in which an assessment term is used (doing work that is relevant to a broader social context). The interview accounts have been examined with regard to the assessment work.

As discussed in Chapter Four, studies by Goodwin and Goodwin, and Pomerantz demonstrate how assessments in everyday talk are sequentially set up and located. For example, Pomerantz shows how a first assessment by one speaker will be usually followed by a second assessment by the hearer[95]. Taking Pomerantz's study as a form of baseline, a number of recent CA studies of institutional data have identified some alternative ways that assessments are used in order to undertake activities relevant to some institutional goal. These studies contribute in different ways and will be considered below.

Antaki, Houtkoop-Steenstra, and Rapley (2000) describe how 'high grade assessment' sequences are used interview data[96]. Their interest in these sequences is receipts done with a superlative, like 'brilliant', rather than an 'ordinary positive' assessment like 'ok' (p236). They argue that such receipts work differently from news receipts, that high-grade assessment sequences claim a closure on the previous turn, marking that it has been successfully completed as a section:

> ...it looks as if the high-grade assessment in that environment is not a comment on the content of the preceding talk, but rather a signal that it has successfully met its local criteria for acceptance as completing a stage in the proceedings (p258).

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[95] An example can be seen in the following data extract:
(NB: IV.7.-44) (Pomerantz, 1984: 59)
A_1 A: Adeline's such a swell [gal
A_2 B: [Oh God, whadda gal
You know it!

[96] The data is from two sources, psychologists interviewing people with a learning disability about quality of life, and interviewing cancer patients about quality of life. The majority of high-grade assessments were found in the interviews with people with learning disabilities (only one was found in the cancer group). An example of a high-grade assessment is seen in the following extract from Antaki et al.'s data:

(4) CA/KK/CD1 102 (Antaki et al., 2000: 238-239)

1	AR	*((throat noise))* I'm ↑better ↑o↓ff	
2	I	↓yer better off ↓ri:ght↑ (.)	*answer receipt + "right"/ok" token*
3 →		**↓jolly ↑good-** (.)hhh	*high-grade assessment*
4		ah (are most?) of the things that yo:u	*next question*
5		do Arthur (.)	

Antaki et al. suggest that assessments are used in this context to emphasise the interviewer's institutional 'impersonality'. They are used to achieve institutional interview-oriented goals, and are talk-oriented, rather than content-oriented, devices. High-grade assessments were used almost exclusively (by the interviewer) to mark topic transition to the next item in the interview schedule. In looking at other non-institutional data they found only one instance of a high-grade assessment being used in this way. They sum up by saying that the high-grade assessment sequences used in this way were a highly salient feature of the interaction, and were a way to mark milestones 'on a path that was rocky for both parties' (p261).

The analysis of assessments by Antaki et al. raises a query over what constitutes an assessment. If the high grade assessments referred to are not being used to do or contribute to assessment work (i.e. to assess something) is it appropriate to label them in this way? The analysts identify terms such as 'brilliant' as assessments without demonstrating how they are set up as assessments. The local contexts set up by participants indicate, as Antaki et al. remark, that the assessments are in fact not used to do assessment work. It is therefore misleading to refer to them as assessments.

Taylor documents how assessments are used in counsellor-client consultations in HIV screening clinics. Terms like 'smashing', and 'that's wonderful' are in this case shown to be doing assessment work. Taylor investigates how clients attending HIV counselling sessions get out of unsolicited offers of tests for other sexually transmitted diseases (STDs). She found that there were 'truncated' and 'extended' acceptance and refusal formats used in the closing of offer sequences. The assessments occur in the post-

acceptance and post-refusal turns in the extended formats[97].

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[97] An example of the notable absence of a second assessment can be seen in the following extract from Taylor's data.

Unlike Pomerantz, Taylor notes that there were no second assessments by the clients. She suggests that the most plausible explanation for the absence of second assessments or the withholding of them in her data may be that members are orienting to the accomplishment of institutional goals. In this sense a particular feature of the talk is 'institutional talk-in-interaction' (p245). The absence of second assessments by clients observed in Taylor's analysis indicates, as in my analysis of research interview data, that within the context of a lay-professional relationships (Collection K) lay people are not competent to comment on the assessments of professionals. This is a feature of institutionality.

Terms like 'marvellous' or 'brilliant' are used to do different types of assessment work. For example, they may be used to make observations of events, or identity work. In Extract 4.1 (Chapter Four, page 100) the interviewee used the term 'marvellous' in order to describe her husband's response to an operation. As with Taylor, such terms are shown to be doing assessment work, a key purpose of which is to achieve the institutional goals of the talk. In both cases assessment terms are clearly bound to some object that is assessed. Antaki et al. show that the terms are used to do institutional work, but they do not demonstrate how they do assessment work.

5.15.2 Membership categorisation and assessment work

(8.28) [Extract 10b 41A D M] (Taylor, 1999: 243)

1	D:	Is that OK=
2	P:	=That's ok yes
3	D:→1	Smashing
4	P:→2	mm hm
5		(4.0)
6	D:	Right (1.3) we'll um (.) pop you back into
7		the waiting room
8	P:	Ahha

MCDA offers a different analysis of how assessment work is done that is complementary to the sequential analyses discussed above. That the utterances examined through MCDA occur within turns is not in doubt. As Schegloff comments:

> ...it is clear that temporality and sequentiality are inescapable: utterances are in turns, and turns are parts of sequences: sequences and the projects done through them enter constitutively into utterances like the warp in a woven fabric (1988: 61).

The analysis of categorisation focuses on membership categorisation in extended turns in interview talk. The way such turns are set up will be examined in Chapters Six and Seven. The CA studies of assessments discussed above are appropriate to data that explicitly displays the turn-taking system in play. Such data allows the absence and presence of second assessments to be systematically observed. However, a great deal of work goes on within long turns where there is minimal response by the hearer. MCDA has been usefully applied to the interview data examined here, where one party does most of the talking.

A key feature of my analysis of assessments in the interview data is the way the interviewees set up lay and professional identities in their descriptions. The approach taken in CA studies is to examine the sequential use of assessments by participants in the talk, including at times the recognisable absence of assessments. Identity work is considered through the sequential way the talk is produced. For example, in Jones's (2001) analysis, the doctors and patients were found to use assessments differentially according to their lay and professional status. As well as sequential practices, members also undertake categorisation work in their talk. However, this categorisation work is not generally attended to in CA analyses. This means that the way identities are set up and used by members through the categorisation work they do is not always adequately described and may lead to assumptions about identities[98]. This can be seen in Heritage and Stivers' analysis of online commentary that was initially discussed in Section 5.8.

[98] It does of course depend on what your research problem is and it may not always be appropriate to undertake such analysis.

Heritage and Stivers provide a valuable analysis of how assessments are used in consultations between doctors and patients. However, their examination of the identity work that members are doing is limited. For example, they ask about the role of online commentary in the process through which patient resistance to doctors' evaluations is disarmed.[99] An absence of patient resistance was found during and after 'no problem' evaluations from doctors, leading to the argument that the analysis points to the use of online commentary in these consultations as embodying 'the cultural authority of medicine'[100]. They make the comment that:

> From the laymen's point of view, her (doctor) observations define the state of these areas. She is culturally empowered to offer definitive conclusions' (Heritage and Stivers, 1999: 1510).

The way this cultural empowerment is produced by lay and professional participants is insufficiently explored. My analysis of assessment work in interview talk has demonstrated how such issues can be (usefully) explored through categorisation analysis of members' talk.

The analysis shows how the interviewees set up lay and professional identities in their descriptions using Collections R and K. This involves setting up roles and responsibilities associated with lay and professional identities. Heritage and Stivers' data differs from mine in that they examine consultations between patients and doctors whereas my data are accounts of health care experiences involving doctors and nurses. Also the data analysed here describes contact with nurses. However, their comment 'from the laymen's point of view' infers a lay interpretation of lay-professional relationships that goes beyond the data analysis they presented. My analysis offers an examination of how the cultural empowerment of health professionals by lay people may come about in research interview talk.

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[99] The online commentary is observed to be a way for doctors to make a strong case for not prescribing antibiotics to patients (when it would not be appropriate).
[100] They take this term is taken from Starr (1982: 14).

Although my examination of assessments started off with relatively short segments of data in which assessments were located, the scope of analysis has expanded (led by members' concerns in the talk) to incorporate other utterances. The analysis has also included the explication of a range of resources used in conjunction with assessment sequences that contribute to the assessment *work* that is done. The study of assessments provides a rich source of interactive work. As described by Goodwin and Goodwin:

> One of the very interesting things about assessments is the way in which they integrate a range of phenomena occurring within the turn that are frequently studied quite separately (1992: 173).

> ...while on the one hand assessments constitute a mode of interaction that can occur within utterances, indeed within subcomponents of utterances, on the other hand they also provide an example of an activity structure that can seamlessly span multiple utterances... (1992: 159).

The study of assessments makes it possible to view the way participants invoke broader social activities beyond the turn in which the assessment is placed. This was seen in Extract 5.1 where IE comments that he did not complain about the nurses he is critical of because 'nurses are in trouble as it is now'. He invokes a broader societal norm about the general situation nurses are in, in order to situate his action (not complaining). This was also seen in Extract 4.2 where IE sets up the nurse she praises as a special person, who is capable of things that she could not do herself. The nature of the assessment work analysed in these interview accounts contributes to the construction of assessments of health care experience.

5.15.3 Assessments of health care experience

Chapter Four highlighted the way in which the machinery used to construct occurrences in talk may produce by-products such as praise, criticism, and emotion talk in the interview accounts, and reassurance for patients during a physical examination in Heritage and Stivers' study. These by-products draw attention to social phenomena that exist beyond the small activity system in which the assessment takes place. They may be invoked and made relevant by participants in the talk. This is discussed by Drew (2001) in his review paper for a special edition of *Text* on 'lay diagnosis' in clinical

encounters (earlier referred to on page 95). He comments that in these studies the lay 'accounts to the doctor reflect – and hence provide a window into – their everyday lives and experiences and concerns' (p265). The 'window' Drew refers to is an example of what Sacks refers to as a by-product (of interaction). Describing the machinery first, as with the study of assessments here, can lead to greater understandings of why things happen in the ways that they do. The small activity systems set up by participants in talk may contain references to the broader projects in which they are engaged.

The data examined has involved analysis of interviews about the death of a spouse. The accounts describe the way health care has been experienced, in particular through the description of lay and professional identity work. This includes setting up entitlements to certain experiences. Assessments are central to producing such accounts. As Bergmann comments:

> Although morality is officially backgrounded in modern institutions and professions, the whole enterprise of people-processing in institutions rests on assessments and decisions about people's normality and moral accountability. (1998: 291)

Assessments are valuable devices used to integrate description to achieve its task.
In identifying how assessments are used in the construction of interview accounts, is it possible to say something about why the interviewees do this complex assessment work? The assessment work contributes to the production of an overall assessment of health care experience.

The assessment of health care experience is the central feature of quantitative and qualitative studies of consumer satisfaction and dissatisfaction with health care. However, the way in which interviewees produce their assessments is not usually described. This analysis has started to demonstrate the complex accounting work that goes on in the production of such assessments, which will have a bearing on how research accounts are to be understood and on their status. Such studies often aim to provide a lay or professional perspective or viewpoint. However, the assessment work analysed here demonstrates that identity work in lay descriptions draws on a broader

social world. The lay person locates their actions and those of others within particular contextual frameworks involving both lay and professional people. Inadequate description of these issues can lead to misguided conceptions of lay-professional relationships. This has relevance to concerns raised about moves by the Department of Health in England to shift the balance of power so that partnerships are developed between health professionals and patients[101]. As Canter (2001) argues, the transfer of 'medical power' from doctor to patient is not as simple as it seems. This analysis of interview data supports other research such as that by Heath (1992) which demonstrates that medical power is not just constructed by doctors, but by lay people too. This is observed in these accounts.

The way in which lay people set up entitlements to experience in their accounts also provides some insight into the finding from studies of satisfaction with health care that communication is the main problem that is raised. The use of assessments in this data indicates that lay people do not constitute themselves as entitled to comment on other (professional) activities. This may be a reason for the majority of criticisms of health professionals being about communication (for example, see Meryn, 1998). Communication difficulties are something that lay people are entitled to comment on.

Setting up entitlements to opinion in this way has implications for understanding patient satisfaction and dissatisfaction. Given policy makers' and researchers' concerns about measuring these notions, it appears to be important to consider how lay people do assessment work and organise their accounts. This will be discussed further in Chapter Nine. Here it can be seen that entitlements to certain experiences are bounded, i.e. expressions of satisfaction and dissatisfaction are limited by contexts that are set up by the interviewees. These constraints are also contributed to by the social organisation of the interview itself which will be seen in two chapters that follow.

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[101] This is evident in numerous policy documents. For example, a stated objective in a recent paper *Patient and Public Involvement in the New NHS* (Department of Health, 1999a) is to promote 'patients' involvement in their own health and health care as active partners with professionals' (p2).

5.15.4 A note on the limitation of the analysis of assessment work

A limitation of the present analysis is that, unlike CA analyses of assessments, there is no systematic 'database' of categorisation analysis in everyday talk available that has examined the use of assessments in detail. The study of everyday talk by Pomerantz in particular, and the work of Goodwin and Goodwin, has provided a valuable comparative resource that can be used in CA studies of institutional data. This has made it possible for CA researchers interested in assessments to consider the institutional functions of assessment work in their analyses. The present study is a step towards building a body of research on the categorisation analysis of assessment work. Similar work is required on everyday talk. This limits the reliability of the analysis (given that it is not possible to compare it with analyses of everyday talk), but not the validity.

PART THREE – DOING INTERVIEW TALK

> The study of interviewing *per se* by the social scientist provides another means of understanding social order and social organization (Cicourel, 1964: 99).

Part Three consists of two chapters which examine the way the talk that is used as data is constructed as the interview. The opening turns of 25 interviews have been analysed using CA in order to describe how the identities of the interviewer and interviewee are set up. The analysis includes how the participants move from 'pre-interview' talk (including 'small talk') into the interview itself, how the story request is made by the interviewer, and how it is responded to by the interviewees.

The two chapters are to be treated as a pair. Chapter Six focuses on the move from pre-interview talk to the interview, and the work the interviewer does in order to set up their opening turn in which a story request is made. It includes a brief discussion. Chapter Seven examines the way interviewees respond to the interviewer's opening request. This is followed by a more detailed discussion of the implications of the analysis from both chapters.

CHAPTER SIX

THE OPENING TURNS: DOING 'BEGINNING AN INTERVIEW'

> If the speaker has a question and has the floor and a turn to talk, why doesn't he or she ask the question instead of asking to ask? (Schegloff, 1980: 104).

6.1 Introduction

The three previous chapters have attended to aspects of the moral work interviewees undertake in describing their experiences of the death of a spouse. The data analysed primarily consisted of one person (the interviewee) speaking. The interviewer was not actively excluded from analysis, but the data did not contain many instances of her talk. Analysis of the categorisation work undertaken by interviewees demonstrated the way in which recipient-design devices, such as course-of-action and inter-subjectivity are used to orientate to the interviewer in the talk. The data has been produced as part of a particular social context, an interview. However, detailed sequential analysis of the talk and production of the identities, 'interviewer' and 'interviewee', was not carried out[102]. This means that the collaborative nature of the talk by participants, as an interview, was not fully explicated.

In line with the ethnomethodological nature of this study, the role which the interview context played in the construction of the talk is considered to be an important element of the data analysis. It means that identities of participants (as interviewer and interviewee) cannot be reliably specified in advance but need to be shown to be attended to in the talk (Schegloff, 1992a). Sequential analysis of the interview data using CA enables empirical investigation of how interviews are constituted as particular social events by participants engaged in them. For example, if an interview is a common form of social interaction, what makes it observable as interview talk and not just a conversation?

The aim here is to attend to how the talk being treated as data is constituted by participants as an interview, and the identity work which that entails. As an example the following extract from the opening of an interview might be considered.

[102] This has been influenced in part by the form of the data with primarily one person speaking.

Extract 6.1 (Interview 12)

22 IR So [(.) what I was going to say is (.) could could you tell me the stor:y of of your
[((paper shuffling----------
23 wife's death would (.) would you be OK to do that (0.2) just tell me (.) what
----------))
24 happened=
25 IE =Yes well hhm [hhm hh ((clears throat----------)) (0.2) erm (0.2) it
26 IR [and I'll come on to more specific questions
27 IE started actually six years ago (0.3) and er (0.2) she had a lump (0.2) we went to

In this extract, the first speaker appears to invite the second speaker to tell a story about an event. In most qualitative research this is where discussion of the interviewer's talk would stop. Interviewers' questions are either not usually reported in conjunction with the interviewees' responses, or are provided in order to give the reader contextual information about the interviewee's response. The analytic interest in most qualitative studies will therefore be the interviewee's response from line 25 onwards.

An alternative perspective, when considering the interactional work that is done in order to produce the story invitation, 'could you tell me the stor:y of your wife's death', is that the invitation is embedded in a sequence of utterances which make up a turn taken by one of the speakers. IR prefaces her story invitation with a pre-sequence[103] about what she is going to say, 'so (.) what I was going to say is (.)', indicating that she has a pre-set agenda that she had intended to follow. She follows this with 'could could you', which projects a request. The request for the story immediately follows. IR does not stop here to let IE respond, but adds a post-sequence, 'would you be OK to do that'. She then repairs her initial request, down-grading it to 'just tell me (.) what happened'.

After this sequence of utterances the interviewee takes it to be his turn to talk and starts to come in with an acknowledgement of the request 'yes well' followed by clearing his throat. IR overlaps IE's throat clearing with an agenda statement, 'and I'll come on to more specific questions', projecting future actions for herself and setting out the format

[103] Pre-sequences 'are utterances produced as specifically prefatory to some activity' (Schegloff, 1972: 109).

of the interview for IE. Saying 'more specific questions' infers that the invitation 'could you tell me the story' is to be heard as a certain type of question. IE acknowledges the request with 'Yes well', then begins the requested story with 'it started actually six years ago'. Analysis of the interactive work undertaken by participants enables the identification of a range of resources participants use, and how they are applied in order to open or start the interview.

This chapter is not intended as an attempt to describe what constitutes an 'interview'[104]. The objective is to describe how the interview as a social process is enacted so as to establish as an accountable pattern of 'meaning, inference and action' (Drew and Heritage, 1992: 5). The analytic focus is the production and use of institutional identities in constituting the talk as 'interview', or in other words, the way in which the identities IR and IE are used by the participants in the talk to do the work of the interview[105]. How does this talk come off as 'interview'? Interview talk is a form of institutional talk in that it (demonstrably) has the following features described by Drew and Heritage (1992: 22):

- goal orientations that are tied to institution relevant identities (here IR and IE);
- members' imposition of special constraints on what will be treated as allowable contributions to the business at hand; and
- members' use of inferential frameworks and procedures that are particular to specific institutional contexts.

The preliminary discussion of extract 6.1 can be considered in relation to these criteria. The goal orientations are tied to institution relevant identities in that one person is set up

[104] This is in line with Hester and Francis' (1994) discussion of 'sociological' interviews. They refer to Garfinkel's comments on 'haecceity' and 'quiddity', commenting that they are not interested in 'quiddity' – or 'whatness'. They take it to refer to what makes something an interview – how can something be identified as an interview. Their interest is in 'haccaeity' or 'thisness' of interviews 'just now, with just what is at hand, with just who is here' (p679), what the interviews consist of and the local circumstances of their production.

[105] This identity work is carried out on a different 'level' than that carried out by interviewees in their accounts. Both types of identity work are invoked in this interview talk. Participants are seen to carry out a range of identity work at the same time. The relationship between these different types of identity work will be considered in the discussion chapter.

as someone who asks questions, the interviewer. She sets out a (pre-set) agenda regarding the types of questions she will ask. A corresponding role, to answer the questions asked, is set up for the second speaker, who becomes the interviewee. The response to the question involves a special constraint in that it is to be about a particular topic, the story of the death of his wife. IR infers that there is some delicacy associated with the task of requesting the story in that she carefully frames it within a number of other utterances such as 'would you be OK to do that', rather than asking outright 'what happened?'.

The way these procedures are used in doing 'interview talk' will be explored in chapters six and seven, through analysis of the interview openings from 25 different interviews[106]. The data analysis in this chapter is organised in two main sections. The first section looks at how participants successfully move out of 'small talk' or 'pre-interview' talk to the interview. This includes the way participants at times refer to the physical context of the interview. In the second section the (sequential) resources used by participants in the opening turns of the interview itself are examined. The resources used include: pre-sequences, agenda statements, story requests, and post-sequences. Analysis of interviewee responses to IR's story request will be undertaken in Chapter Seven. A discussion of the implications of the analysis in these two chapters will be included at the end of that chapter.

6.2 Moving into 'interview talk'

How do participants set up and orient themselves to the talk as an interview rather than as everyday conversation, or other types of speech-exchange system? Interview data is usually collected as part of an interaction between two people, the interviewer and interviewee. It is part of a process that includes a number of stages. For this study the process involved the following stages: letter to prospective participants; visit to

[106] I started off the analysis for this chapter looking at the interactive work between IR and IE throughout the interviews. It was decided to focus on the opening turns of the interview in detail as almost every interview had a recorded opening which would facilitate comparative analysis across a number of interviews.

prospective interviewee; explanation about the study and what is expected of the interviewee; request to do an interview; setting up time for the interview; visit on day of interview; chatting (cup of tea etc.); information about the study; signing of consent form; interview (data collection); chat; goodbye.

What is referred to here as the interview is formally set up and oriented to by the participants as a specific type of activity. As seen in Extract 6.1, the initial 'question' of these interviews, 'tell me the story of what happened', is one of a number of related utterances that make up the opening turn of the interviewer. Participants need to do work to set up the opening turn and formally start the interview. The way in which participants manage the transition from pre-interview to interview talk is the first step[107]. Thus, this section initially will consider how participants move out of small talk[108], before looking at the related issue of how the physical context is referred to in both pre-interview[109] talk and in the opening turns of the interview itself.

6.2.1 Moving out of small talk

Unlike some other classes of speech event such as conversations between spouses (Turner, 1972: 368), interviews require that beginnings be announced in some way. Given that the interview is part of a broader process of interaction, this requires negotiation of a move by participants from pre-interview talk to interview talk. Turner considers how 'starting' is formulated as a visible event in talk between participants in a therapy group:

> ...the scheduling and concerting of activities makes it an issue for a vast range of social occasions that participants must *assemble* over time before the occasion "begins," and that there may be (a)

[107] I am treating the 'interview' here as the talk that would constitute the data to be analysed for the study. Analysis has been carried out from where the audio-taped talk begins to the end of the story. The rest of the interview has not been included in the analysis for this thesis. The amount of 'pre-interview' talk taped varies. The case was included if the opening was recorded sufficiently to see how the talk was collaboratively produced.

[108] Although I refer to this talk as small talk, discussion of interview practice by experienced researchers indicates that it may be an important element of the work of getting an interview done. For example, Oakley (1981) argues that building up rapport with interviewees is integral to undertaking qualitative interviews. Small talk may be part of the preparatory work necessary for carrying out a 'formal' interview.

[109] Pre-interview talk may include small talk, but also other talk related to the task of the interview. It is taken here to refer to any talk that occurs before the formal start of the interview.

> formal markers establishing when the occasion is warrantably in progress (such that activities which were formerly permissable are now "interruptions" or "disruptions"), and (b) recognized, displayed and sanctioned features of the occasioned activity which are not warrantably available to participants before the occasion begins... (1972: 369).

Special opening procedures are commonly associated with institutional talk (Drew and Heritage, 1992). Turner demonstrates through analysis of group therapy data that starting is an activity undertaken and oriented to by participants[110]. His analysis shows how therapist and clients manage the shift from everyday talk into 'therapy talk'. It is not merely an observer's judgement that participants are now doing therapy talk, or as in the data analysed here that they are now doing interview talk. Turner argues that doing and recognising 'beginning' is carried out through the use of standard markers that are generally available, such as 'you mean we've started' and 'look before we start'. This can similarly be seen in the interview data extract below (which includes Extract 6.1). The participants engage in everyday small talk in lines 1-9, such as IE's comment in line 7 about how 'time flies'. In lines 10-21 the small talk continues but is interspersed with references to the task ahead (the interview). The interview is formally started on line 22 when IR makes her request for IE's story.

[110] It can be seen in the extract below how therapist and group members negotiate beginning the group therapy session by doing 'accountable absences'. They initially discuss what constitutes the group for the purposes of this particular session 'Just us merry three?', before the therapist goes on to suggest formally starting on line 6.

Turner, 1972: 372

1 X..	Just us merry three?
2 THER.	So far....um, Joan won't be here today, or at least she thought she
3	Might not because her father was coming down to get her...but
4	Uh she hoped to be here next week.
5 A.	I hope this is the bit about being got by her parents. (( ))
6 THER.	Well, we might as well start.
7 ?.	It's kind of hard to start if our subject's not here today.
8	/laughter/
9 A.	Well, the subject's got her own troubles ((which)) we don't know
10	Whether she's comin or going yet do we? Or goin or stayin.

Extract 6.2 (Interview 12 – extended version of Extract 6.1)

1 IE 20th wedding anniversary (0.2)

2 IR Oh right (0.2) how many daughters have you got=

3 IE =two (0.4) that's those two there (.)

4 IR right (0.4)

5 IE Er (.) we came through in (.) third month in it (0.4)

6 IR ( ) (0.4)

7 IE time flies (0.2)

8 IR well it does actually I can't bel yes (.) cause its (0.2)

9 IE Heh heh heh heh=

10 IR =is it the first of March today (0.2) I keep thinking it's the 29th of February but

11 of course it isn't hhh (0.2)

12 IE No [its er

13 IR [so I'll leave it there's a copy for you as well [you see so you know what's

14 IE [that's gorn

15 IR [( )

[((paper shuffling))

16 IE ( ) yeah that's gone I'm afraid (0.2) [February (0.2) hhhm

[((paper shuffling ----------

17 IR Ye:s (.) it doesn't seem long since Christmas (.) [next Christmas is coming now

---

18 IE [heh heh heh heh heh heh

19 (1.8)

20 IR bits of paper (.) I've got so many bits of paper at work=

----------))

21 IE = yeah that's the trouble isn't it (0.2)

22 IR→ So [(.) what I was going to say is (.) could could you tell me the stor:y of of your

[((paper shuffling----------

23 wife's death would (.) would you be OK to do that (0.2) just tell me (.) what

----------))

24 happened=

25 IE =Yes well hhm [hhm hh ((clears throat----------)) (0.2) erm (0.2) it

26 IR [and I'll come on to more specific questions

27 IE started actually six years ago (0.3) and er (0.2) she had a lump (0.2) we went to

The formal start to the interview is set up and oriented to by participants over a sequence of pre-interview talk. The connection between pre-interview and interview is negotiated by participants, who move from small talk to interview talk over a series of turns. The talk in lines 1-9 is managed as everyday conversation or 'small talk'. It involves talk about family members and the passing of time. From line 10 to line 20 there is an evident shift from the earlier small talk to more formal talk, in particular on the part of the interviewer. This is still pre-interview talk, but an element of formality is introduced into what had been small talk. In line 10, IR asks IE for clarification of dates, staying on the topic of time commented on by IE in line 7, 'time flies'. IE begins to respond with 'no its er', but IR overlaps this with a new topic about a document, 'there's a copy for you as well'. IE does not respond to either being given the document by IR or her comment about it. Instead he sticks to the small talk, overlapping IR's comment about the document with a further reference to the date initially raised by IR on line 10. IR makes an inaudible comment, which is followed by a further reference to the date from IE, 'that's gone I'm afraid (0.2) February'. This time IR picks up on this small talk again, acknowledging IE's comment on line 17 with a 'yes' and a further small talk comment about Christmas to which IE responds with laughter.

IR begins the interview on line 22 with the preface 'so (.) what I was going to say is', followed by the request 'could could you tell me the story of your wife's death'. A so-preface can be used to forecast that the talk that follows is connected to something prior, or that it is the upshot of the prior talk (Rapley, 2001b). By using 'so' to connect what follows to the preceding talk there is an indication that the following talk is different from preceding talk (therefore it needs to be connected). In this way IR marks up a formal start to the interview, both separating and connecting the talk that follows to the preceding or 'pre-interview' talk. The second part of the request preface 'what I was going to say' indicates that IR has a preset agenda which will be stated following the preface. The 'so' provides the connection.

Setting up a formal interview opening may additionally require attention to the physical context of the talk. Technical aspects of the interview, such as paper work and

extraneous noises, may be made relevant at times by interview participants and if so, need to be managed.

6.2.2 Referring to the physical context

In addition to the talk going on between participants in Extract 6.2, a non-talk activity is introduced on line 15 and made relevant to the talk-in-interaction by both IR and IE. Audible paper shuffling can initially be heard on line 15. This comes shortly after IR's comment 'there's a copy for you as well'. There is then an extended episode of paper shuffling between line 16 and 19. During this IE and IR initially make comments about time ('February' and 'Christmas'), before a long pause of 1.8 seconds on line 19. The gap is not heard by IE as a possible turn transition point. He does not take this as an opportunity to carry on the small talk or initiate a new topic. This indicates that he is deferring to IR as someone who will take the next turn and introduce the next topic. The orientation to this type of turn-taking system is indicative of a specific reduction in the range of options for action characteristic in conversation (Drew and Heritage, 1992). The pause, together with the subsequent comment about 'bits of paper' and the audible paper shuffling, indicates that IR is doing some paper work during the pause. The comments work as a kind of online commentary (Heritage and Stivers, 1999)[111] with IR informing IE about what they are doing while shuffling papers and making it relevant to the interaction between them. It is a reference to the physical context of the interview and foregrounds the official business now at hand. IE produces an agreement that acts like a maxim, 'yeah that's the trouble isn't it'. Both participants use it to bring the broader context of the interview into play.

The action of referring to physical documents in institutional talk-in-interaction is examined by Allistone (2002) in his analysis of talk between parents and teachers in school parents' evenings. He shows how the teacher 'integrates the audible manipulation of documents as an element within the (previously outlined) initiatory work marking the shift from pre-talk to reporting structure' (p129). The action of the

[111] Online commentary was also discussed in Chapter Five, page 132.

teacher 'looking' at the written documents on pupils provides justification for moving into the formal reporting structure. The teacher uses the written record as:

> ...a specifically local interactional resource which, intentionally or not, sets up a series of different relevances through which T (teacher) can affect a change in the course of the talk (p127).

> ...the inclusion of a paper shuffling turn within the sequence allows the teacher to retain the floor across a potentially accountable period of non-conversational silence. (p129)

In this way the manipulation of documents plays a role in accounting for periods of silence. In Extract 6.2, a long period of paper shuffling begins on line 16 when IE is talking. IR talks during most of this, but the paper shuffling at line 19 allows her to retain the floor during the 1.8 second non-conversational silence[112]. IE allows her to hold the floor and carry on with her paper shuffling. IR comes in on line 19 with a direct reference to the paper shuffling, 'bits of paper (.) I've got so many bits of paper at work'. This allows her to integrate the paper shuffling into her interaction with IE. It is expressed as a form of complaint or trouble by IR and is heard in this way by IE, who responds to her comment, 'yeah that's the trouble isn't it'. These two utterances can be heard as small talk but are also doing institutional work. The participants collaboratively account for the paper shuffling and non-conversational silence as a no-fault situation. The verbal silence during the paper shuffling is an indication that participants are orienting to an institutional task, rather than making everyday conversation where looking down at papers might be accountable. This demonstrates the nature of the talk as 'interview' in the sense that:

> ...participants will produce interviews in which overwhelmingly one party produces questions and the other answers, because the latter party will not talk where talk might otherwise be done if a question has not been asked.... (Schegloff, 1992a: 123)

[112] It is also likely that during this time there was no eye contact between IE and IR. The paper shuffling also allows IR to hold the floor during this period, without accounting for her actions.

The physical context is also referred to at times after the interview has formally been started with IR's turn in which the story invitation is made. This can be seen in the three extracts below. In all three cases there is reference to the tape recording of the interviews.

Extract 6.3 (Interview 19)

1 IR can you tell me the (0.2) story of what happened (0.3) and then go on to more
2 specific [questions (0.2)
3 IE [((clears throat))
4 IE Yeah (.)
5 IR because that helps to set the scene really and=
6 IE =Yeah ( )
7 IR ( ) ((paper shuffling 3.5)) OK whenever you're ready=
8 IE→ =OK is it alright like that?=
9 IR =Yeah (.) because its on tape heh heh so I [write down] I write down some
10 IE [( ) heh ( ]
11 IR things but=
12 IE =yeah .hhh I suppose it started really erm (.) she used she used to be a smoker
13 (0.1) a few years ago (0.2) and then of course she'd stopped anyway (0.2)

Extract 6.4 (Interview 3)

1 IR you know the services you recei:ved and what hap some of it actually you've
2 already told me [so I can make a note of it but erm=
3 IE [mhm
4 IE→ =oh right (0.2) am I on? (.)
5 IR Yeah you're on (.) but don't worry heh heh heh heh hhh. you don't heh I your
6 name isn't on it or anything like that [and no-one will know its you and I lock
7 IE [No
8 IR them away and then we're going to I just put (.) I've got a code number you
9 you see=
10 IE =Oh I see

Extract 6.5 (Interview 23)

1 IR→ Its sort of quite good at picking up (0.4) [( )
2 IE [heh heh heh heh
((dog barking-----
3 Alright we'll have [the dog in the background they'll say [that's
4 IR [and the dog noises
----------)) [((dog bark))
5 IE charming isn't it (.) heh heh
6 IR Erm how did it (.) could you tell me [the story of what happened
[((dog bark))
7 IE Well (.) erm (0.2) I think it was in (0.2) (1995)

In Extract 6.3 there is a long period of paper shuffling on line 7 which is not commented upon by IE or IR. IE waits until this is finished and for IR to make a comment before responding. IR just says 'OK whenever you're ready', indicating to IE that she is now ready to hear their response. IE indicates that he is ready by saying 'OK', but then rather than coming in with his story he asks a question 'is it alright like that?'. This appears to refer to the materials IR is using to make notes on the interview, as IR mentions writing things down. In this extract it is not IR who initiates a comment to IE about the physical context of the talk, but IE who raises it so that IR must respond. In Extract 6.2, invoking the physical context indicated that it was her role to prepare for the interview by sorting out the papers. IE orients to IR's role by waiting until IR speaks. In Extract 6.3 IE is seen to invoke the physical context on line 8, by checking that things are in order so that IR can conduct the interview. They are monitoring the physical context by checking that things are prepared.

In Extract 6.4, it is the interviewee again who invokes the physical context, but this time in a different way. The end of the story invitation is heard, followed by a comment about having already heard part of the story by IR. However, after an initial response 'oh right', IE does not go straight into the story or query where it should begin. Rather she makes a reference to what can be understood as the tape recorder, 'am I on?'. This

implies that IE takes it that there is a particular point at which she should begin her response. This is again an indication that a formal opening to the interview is oriented to by IE who takes the tape recorder being turned on as a marker that she should begin. It shows that IE is aware of the tape recorder. It is notable that she does not say 'are we on?' or 'is the tape recorder on?'. This also indicates that IE is orienting to the interview as being about her responses, not the interviewer's questions. IR picks up on IE's question saying that she is on, and then provides reassurance as to the confidentiality of the talk (which is not requested by IE). This implies that IR takes IE's question as a concern with the physical context of the talk.

The final extract in this section (Extract 6.5) includes two types of reference to the physical context. One is to a technical aspect of the interview, and one is about extraneous noises made by a dog. IR makes a comment about the tape recorder on line 1. This is referred to by IE on line 2, who laughs and comments about the dog barking being recorded during the interview. She says '*they'll say* that's charming isn't it' inferring that this talk is produced for an audience other than IR and IE, who are not present[113].

This is pre-interview talk, as it is not the work of the interview but the participants do allude to the task at hand by commenting on the dog barking. IE comments that the dog barks will be heard on the tape. IR also comments on the dog barking. IE makes a joke of it saying 'charming isn't it', and laughs rather than apologises. She also says 'we'll have the dog in the background' indicating that the interview is a joint production between herself and IR. Her comment 'they'll say that's charming isn't it' also shows that the interview is jointly produced for an external audience. IE makes explicit her orientation to recipient-design, indicating that ideally the dog barking would not be recorded as part of the interview.

[113] Orientation to a separate audience for the talk produced in the interview setting is evident in news interview data analysed by Heritage and Greatbatch (1991). They found that participants oriented at times to an overhearing audience, but this was found to emerge only intermittently over the course of an interview.

6.2.3 Summary

The interview is set up and oriented to by both interviewer and interviewee as part of an ongoing process of interaction. This can be seen in the way that participants move out of small talk to set up a space formally for the interview to formally start. This space is for a turn which IR will take to start the interview. References are made at times to the physical context of the interview, such as external noises and technical aspects of the interview like tape recorders and documents. These can appear before the interview's opening turn by IR, or afterwards. Either IR or IE can raise such issues and both contribute to setting up the task of the interview whether it occurs before IR's opening turn or after it. Both IR and IE begin to orient to their roles as interviewer and interviewee in pre-interview talk, with IE deferring to IR as the person who will start the interview. Comments about physical context are not to be heard as directly related to the content of the interview talk but they are relevant to achieving it. This is monitored by both participants.

6.3 Interviewer's first questions: requesting a story

Having moved from pre-interview talk to the interview itself, the interviewer produces a formal interview opening. Earlier discussion of IR's first turn of the interview in extract 1 showed that the central action is an invitation for IE to tell his or her story. However, the interview is not opened with a direct question by the interviewer such as 'what happened?' The initial question in these interviews, 'tell me the story of what happened', is one of a number of related utterances that make up the opening turn of the interviewer. This includes pre- and post-sequences, agenda statements, repetition, and use of the course-of-action device. The interviewer working collaboratively with the interviewee uses these resources to formally open the interview so that the task, of producing a completed interview (as a unit of data), can be achieved. Pre- and post-sequences and agenda statements will be examined here in turn. Use of repetition and course-of-action are included in Chapter Seven.

6.3.1 Pre- and post- sequences

Orientation to the requirements of recipient-design means that prior to activities such as making requests or invitations, speakers may do work to prepare the hearer for what is to come (Sacks, 1992; Silverman, 1998a). This 'pre-sequencing' was seen in Extract 6.1, where IR prefaces the story invitation with a pre-sequence, 'so what I was going to say is (.) could could you'. The pre-sequence projects a next action for IR, that of a 'telling' (Schegloff, 1980: 107). Schegloff refers to such utterances as 'preliminaries' or 'pres'. Preliminaries are used to project tellings or requests. Where preliminaries are used by speakers to project a question or invitation they mark up an upcoming question as delicate (Schegloff, 1980; Silverman, 1997; 1998a). Post-sequences are also sometimes added after the action, such as inviting a story, has been carried out. They also work as preliminaries and function to set up actions as delicate. Here IR uses 'expressive caution' in her opening turn, which produces the story invitation as a delicate topic (for her).

The work that pre- and post-sequences do can be seen in the two data extracts below. The story invitations are in bold to highlight the way they are embedded in IR's opening turn.

Extract 6.6 (Interview 1)

1	IR→	make some notes as well (.) [as well as tape recording it (.) I'd like you to (.) it
2	IE	[yeah
3	IR→	**the first question I'd like to ask is for you to tell me (.) the story of what happened** if
4		you wouldn't mind (0.4) just to kind of give me an idea (0.2) [and then I'll
5	IE	[well
6	IR	come onto more specific questions (0.2)
7	IE	well it go it goes back quite some time about (.) 5 or 6 years ago (.) er (0.2) on a
8		thursday it's a day like this (0.2) pouring with rain hhh.

Extract 6.7 (Interview 2)

1	IR→	Erm hhh. well the first thing I was going to say could you tell me (.) I was going to
2		ask you an op (.) quite an open question say **could you tell me the story (.) of (0.2)**
3		**of what happened** (.) and then I'll come on to more specific questions if that's OK=
4	IE	=Uhm (.) yes well (.) basically (0.2) erm (.) well I retired in (0.4) 1985 (0.4) and er (0.2)
5		about a week after (0.5) ((name)) was asked by a friend down the road (.) to go and have a
6		breast (0.1) X-Ray thing you know and that was down at ((names)) hospital and I drove

In Extract 6.6, IR starts to open the interview with a preface[114]. Prefacing is key to setting up 'the right to produce extended talk, and ways that the talk will be interesting, as well as doing other things' (Sacks, 1992: 226). The preface includes two pre-sequences, 'I'd like you to' and 'I'd like to ask' which work to set up IR's right to extend the turn and indicate to the recipient that she is going to make a request of them. The pre-sequences start to set up a turn design that implicates the recipient in possible future tasks. In the second pre-sequence IR identifies herself as someone who asks questions, setting up her role as interviewer. She identifies her role and indicates what her responsibilities are, i.e. as the one who will ask questions using the pres-sequence to define clearly the boundary between the two participants in this talk. However, the pre-sequences show that she does not take this identity work for granted[115]. In these two pre-sequences IR is also setting up the recipient's role as interviewee, someone who will be asked questions, 'I'd like you to', and 'I'd like to ask'. It is implied that IE will allow IR to ask questions. IR therefore implies that her role as interviewer is contingent on the interviewee accepting the role she is requesting them to take[116].

In Extract 6.7 IR again uses pre-sequences, which are worded differently but have a similar import. IR says '(the first thing) I was going to say', then goes straight on to

[114] The first two utterances (lines 1 and 3) refer to the physical context of the interview and are not taken here to be the start of the opening turn of the interview, but as completion of earlier, related talk.
[115] It is of note that such identity work is carried out by the interviewer even at this stage there has already been considerable interaction between participants in which work setting up the identities of interviewer and interviewee can be assumed to have taken place. It is an ongoing (local) concern for participants and demonstrates Heritage's (1984) point that utterances are both context-shaped and context-renewing.
[116] This is in line with Ackroyd and Hughes's (1992) comment that delicate negotiations have to be undertaken when conducting interview research, as it cannot be taken for granted that the interviewee will do the interview.

'could you tell me' without a gap. She starts to make the request but then repairs it to insert a question preface, 'I was going to ask you' before another pre-sequence and story request, 'could you tell me the story'. In this way she projects the question she will ask.

As discussed above, detailed preliminary work goes on when actions are being projected. In preliminaries, terms may be introduced without being used, and in projected actions, they may be used without being mentioned (Schegloff, 1980). Here a question is projected, but the realised action is a request. Making a request as opposed to asking a question displays to IE that it is not taken for granted that she will respond to what has been requested. The request allows IE to make the decision whether to respond. IR's pre-sequences, 'I was going to say' and 'I was going to ask', indicate that IR has a preset agenda, but they also demonstrate reticence in asking a direct question of IE in the opening turn of the interview. The prefacing work carried out by IR sets up the story request as a somewhat delicate matter for IR[117].

In extracts 6.6 and 6.7, IR says she is going to ask a question, but instead makes a request. One function of projecting the action of asking questions (even though the action is not a question but a request) is to set up the identities, IR and IE, in the talk. Schegloff (1980) highlights a number of issues about how people ask questions in ordinary conversation. He queries why speakers who have the floor and a turn to talk still ask if they can ask a question. This point can equally be raised in relation to the interviewer's talk in the extracts above, where IR has the floor and a turn to talk, but does not ask a direct question of IE. Schegloff's data analysis demonstrated the following points:

- People often project questions, but the question projected does not usually immediately follow the projection.
- In these occurrences, it is not questions that are projected but tellings and requests.
- This produces a type of turn format which has two main features:

- A speaker projects the occurrence of some type of turn or action by mentioning either what she will do, e.g. 'Let me ask you a question';
- The projected turn or action does not occur in the same talk unit (e.g. the same sentence), but is replaced there either by the name of the action, by a pronoun ('Lemme ask you this'), or by a 'dummy term' ('Lemme ask you something').

The pre-sequences examined above act as what Schegloff (1980) refers to as 'requests for permission' for IR to ask a question of IE. In extracts 6.6 and 6.7 IR provides more requests for permission by adding a post-sequence, 'if you wouldn't mind' (Extract 6.6), and 'if that's OK' (Extract 6.7), after the story request.

In the extract below, from Schegloff's data, it can be seen that although the speaker projects a question on line 5, they do not immediately ask a question. It does not come until line 14.

Extract 6.8 (Schegloff (1980): BC, Red: p190)

1	B°:		I've listen'to <u>all the things</u>
2			That chu've said, an' I agree
3			with you <u>so</u> much
4	B°:		Now,
5	B°:	→	I wanna ask you something,
6	B°:		I wrote a letter.
7			(pause)
8	A:		Mh hm,
9	B°:		T'the governer.
10	A:		Mh hm:,
11	B°:		-telling 'im what I thought about
12			i (hh) m!
13	(A):		(Sh: : : !)
14	B°:	→	Will I get an answer d'you think,
15	A		Ye : s/

[117] Also see chapter three where interviewees were seen at times to set up events as delicate matters. Here requesting the story is set up as a delicate matter by IR, but is not treated as such by the interviewees. This will be seen in Chapter Seven.

Schegloff observes that in these occurrences, it is not questions that are projected but tellings and requests. In the research interviews, even though described by IR as questions, the actions projected are requests. Schegloff provides other instances which show that what follows a request to ask a question e.g., 'Lemme ask you a question', is a question, but is clearly not *the* question that the request has projected[118]. In extracts 6.6 and 6.7, IR projects a question, but makes a request. However, unlike the extract from Schegloff's data set above, the request does directly follow the action projection. Further analysis by Schegloff (1980) demonstrated that where question projections were followed directly by *the* question, and the question does not appear to be preliminary to any further actions, the projected question is marked as delicate. Setting up the story request as delicate appears to be an important function of the use of preliminaries by IR in the interview data.

6.3.2 Producing the story invitation as a delicate issue

Bergmann (1992) and Silverman (1997) both highlight the way in which expressive caution may be used to foreshadow delicate issues. It is used to mark and manage delicate items (Silverman, 1997). Part of the work of pre-sequencing here is to mark up the request for the story of 'the death/what happened' as somewhat delicate. Pre-

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[118] **(6) [BC, Red: 196]**

1	A:	Driving a car, sometimes, you-
2		you get-yuh id-you get- almos'
3		tunnel vision sometimes,
4		be cause-
5	B: →	[W'll lemme ask yuh some thing.
6	A:	[-yer=
7	B:	D'you-
8	A:	=[Looking at all the things where
9		d'car's goiing, a:nd sometimes you
10		don't see what's happening on the
11		[street.
12	B: →	Yeah, but d'you know-d'you know
13	→	Queens Bouevard,
14	A:	Yes ma'am.
15	B:	Well you know they have like uhm
16		li-uh well I guess they call-
17		where- I don'know 'f they do,
18		but they-like the service roa: :d,
19		((etc.))

sequences such as 'could you' (Extract 6.7) and 'I'd like to ask' (Extract 6.6) set up the actions that follow as requests. Requesting a story rather than directly asking for it means that it is not automatically expected that the recipient will provide the required response. In this way IR is 'expressively cautious' in how she asks for the story, marking up the request for this particular story as delicate for her. However, although requesting the story is marked up as delicate by and for IR, this does not necessarily mean that the nature of the topic is delicate. This will be explored further in relation to interviewee responses in Chapter Seven.

Despite setting up the request for the story as a delicate issue, the requests are not set up as 'personal' issues on the part of IR. This can be seen in Extract 6.9 below.

Extract 6.9 (Interview 27)

1	IR →	( ) erm (0.2) what I do is as a first question I ask is erm (.) quite an open
2		one can you tell me story of what happened (.)
3	IE	Yes=
4	IR	=and then I go on that gives me an idea (.) and then I go on to more specific
5		qu[estions
6	IE	[Yes (.) well first of all what happened was that (0.2) er (.) she hadn't been
7		(0.2) she hadn't been well for (0.4) oh (0.4) nearly ten years I suppose but (.)
8		nothing (0.3) specific (0.2) er you couldn't pinpoint it down

On line 1 IR uses a pre-sequence to describe how the following action is to be heard by IE. Saying, 'what I do is as a first question I ask' shows IE that what follows is 'nothing personal'. It is something that IR asks other people too. It indicates that she is following a pattern and not treating IE as different than anyone else. However, rather than working to produce the request as a matter of fact action, it still is a case of expressive caution and produces the story invitation as delicate. In setting out the nature of the talk that follows she is attending to a need to explain her actions to IE.

The right of the interviewee to decide whether to participate is sometimes followed through in post-sequences added after the story invitation. For example, in Extract 6.6 IR comes in with a post-sequence, 'if you wouldn't mind', offering IE another opportunity to refuse to tell the story. In Extract 6.7, IR adds 'if that's OK'. As with the pre-sequences discussed above, the use of post-sequences of this type is a form of expressive caution, used to constitute the previous action as delicate. Despite their positioning after the action, they are clearly to be understood in relation to the previous action, and in this way act as preliminaries. They are not stand-alone utterances. They also work to produce the story invitation as a request rather than an ascribed task.

Post-sequences also give the recipient the opportunity to raise any problems of understanding. However, Schegloff (1980) comments that although speakers often give the recipient the opportunity to raise any problems of understanding or recognition, recipients typically do not take up this opportunity. In the interview openings examined here, sometimes there are queries, and sometimes the interviewee embarks on their story immediately without making a query. This will be examined in chapter seven.

The identification and management of issues as delicate tends to be co-operative between speakers (Silverman, 1997). So, before the nature of the topic as situationally delicate can be fully analysed, the way in which interviewees treat the requests needs to be examined. This will be taken up in the next chapter.

6.3.3 Summary

IR's use of pre- and post-sequences as prefacing work in relation to her request for a story from IE marks the request as a delicate topic for her. The way she uses prefacing is not the same in each interview, but she generally uses one or the other to constitute the story invitation as something that requires careful handling *by her*. Using pre- and post-sequences such as 'could you', 'if that's OK', and 'if you wouldn't mind', allow IE to accept or not the invitation to tell the story. They convey to IE that a response is not taken for granted.

Another part of prefacing work in interview openings is the use of agenda statements by the interviewer. The agenda of the talk has begun to emerge through analysis of the pre- and post-sequences used by the interviewer, and discussion of projected questions and requests. The way in which the interviewer makes explicit reference to the agenda of the talk in her opening turn will be examined in the following section.

6.4 Agenda statements

In the majority of extracts discussed above, it is clear that IR refers to a preset agenda. In fact she is fairly explicit about her agenda for the talk in both her first turn and future turns. The agenda statements take the form of setting out the order and types of questions she is going to ask, for example, 'the first question I'd like to ask', 'then I'll come on to more specific questions' (Extract 6.6), and 'the first thing I was going to say', 'then I'll come on to more specific questions' (Extract 6.7). These statements also project further turns and turn types.

Setting up an agenda is pertinent to the turn-taking system the talk will follow, and to getting the work of the talk done, i.e. the interview. This differs from everyday conversation where the content and length of a turn is not usually specified in advance (Sacks et al. 1974). Here it is specified in advance, but is marked up as such, in line with a goal orientation tied to the institution relevant identity of the interviewer (Drew and Heritage, 1992). In institutional speech-exchange systems such as interviews, 'the turn-taking organization employs, as part of its resources, the grosser or finer pre-specification of what shall be done in the turns it organizes' (Sacks et al. 1974: 710). Agenda statements contribute to setting up a task or goal for the talk 'of a relatively restricted conventional form' (Drew and Heritage, 1992: 22). Both interview participants orient to this. IR formally sets out the institutional task, but as seen in the discussion of moving out of small talk and physical context above, interviewees orient to a turn taking system where it is IR's role to state the task. They do this by allowing a space to be created for IR to take the opening turn.

Agenda statements are used to set out a role for the interviewer (to ask certain types of questions), and by implication a role for the interviewee (to answer them). A function of agenda statements, as with other prefacing work, is to instruct the recipient as to what will come next, how it should be heard, and how to respond to it. This is seen in the way people set up jokes through announcements such as 'I heard something funny the other day'. Through this the recipient knows that they are to hear what follows as something funny, and know how they should respond (Sacks, 1992).

The availability of a range of possible ways of saying something means that 'a speaker's selection of a particular formulation will, unavoidably, tend to be heard as 'motivated' and perhaps chosen' (Drew and Heritage, 1992: 36). Agenda statements are selected and used by the interviewer to make explicit a particular type of turn design, through pre-allocating questions and answers, as with much talk in institutional settings (Drew and Heritage, 1992). It is both an action selection, and a 'selection of how the action is to be realized in words' (Drew and Heritage, 1992: 36). It indicates what it will take for the turn to be completed.

The use of agenda statements by interviewers will be considered in relation to two extracts below.

Extract 6.10 (Interview 30)

1	IE	Yes [yeah that's fine (0.2)
		[((papers shuffling))
2	IR→	erm (.) so what I start off with is erm like quite an open question (.) [and then
3	IE	[yes
4	IR→	go onto more speci[fi:c things (.) erm so could you tell you me the story of
5	IE	[( )
6	IR	what happened and then that gives me=
7	IE	=Well [until four weeks before he died we didn't know he had ((tape
8		[( )
9		interrupted))

Extract 6.11 (Interview 6)

1	IR→	and then (0.2) just (.) as that that's a kind of like a general question at the beginning
2	→	and then I'll come onto more specifi:c (.)
3	IE	What=
4	IR	=things (.)
5	IE	what whe what first happened?=
6	IR	=yeah (.) yeah=
7	IE	=my husband felt sick (.)
8	IR	Yeah=
9	IE	=and erm he went to bed for a couple of hours (0.3) and then he got up and I said
10		do you feel better (.) so he said he felt a bit better but he had just a little pain

In Extract 6.10 IR uses an agenda statement at the start of her turn on line 2, 'what I start off with is erm like quite an open question'. This marks up the beginning of the interview. The 'so' preface which precedes it links the talk that has gone before with the interview. The agenda statement is part of the prefacing work IR does before making a request for IE's story. It enables IR to project future actions. She indicates that there will be a first action, which is what she will 'start off with'. Saying that something will be started indicates that other actions will follow. IR infers that the first action is one of a series of things she will do, and that it is part of a preset agenda. The first action here is 'quite an open question'. She adds a second agenda statement after the first, 'and then go onto more specifi:c things'.

The agenda statement lets IE know that IR has a preset agenda to follow, and what form it will take, i.e. 'open' and 'specific' questions. The open question will come first. The agenda statements set out the task of the interview, and the roles of the participants. A turn taking system is set out for the interview in which IR will ask an initial 'open' question, this will be followed by IE's response, which will be followed by 'more specific questions' by IR. Although IR does not specifically say that IE is to respond she uses agenda statements to state that there will be a series of questions she will ask. This sets out a turn system in which it is implied that IE will take up the turns IR sets up for them. As well as the turn taking system being set out, the actions at each stage are specified in Figure 6.1 below.

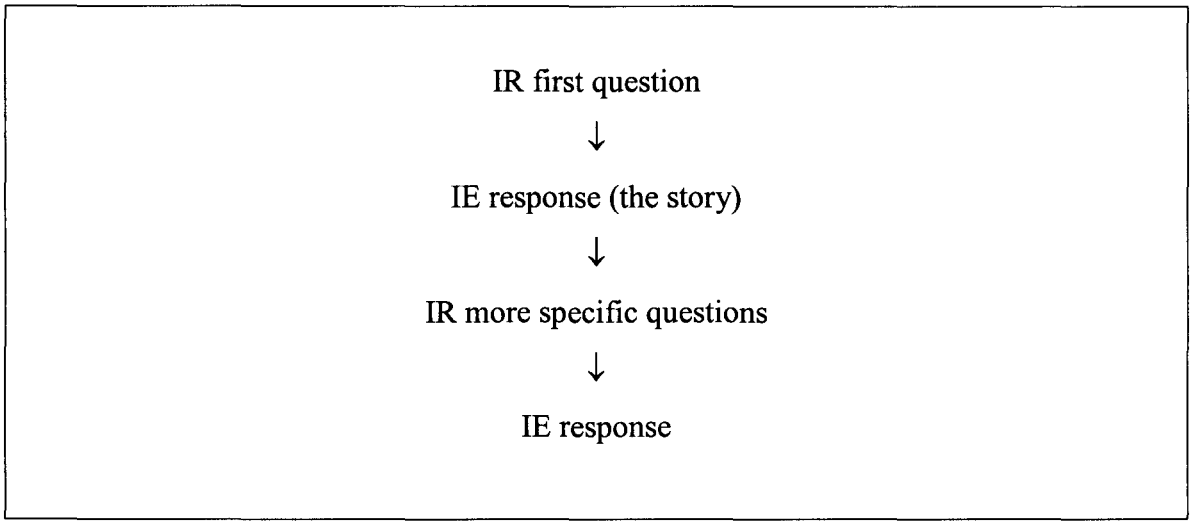

Figure 6.1 - Interview turn-taking system (projected by IR)

In Extract 6.11 what appears to be the end of IR's opening turn has been picked up where the story request has already been made. Two agenda statements are added after the initial request. She retrospectively describes the story request as a particular type of question, 'kind of a general question', and states that this is 'at the beginning' of this particular sequence of talk-in-interaction. Although it is positioned after the story request, it is treated as a preface or preliminary as discussed in relation to pre- and post-sequences above. As with story prefaces, it indicates what it will take for the story to be done (Sacks, 1992; LC2: 19). IR's second agenda statement about 'more specific questions', as in Extract 6.5, is also part of the general prefacing work to the story (projected action). It is used to project a future action for IR after the story has been told by IE. It also indicates that he or she will be listening to the story (be the hearer) as it is told and informs IE of what IR's role will be at the end, i.e. he or she will ask specific questions. In her opening turn IR uses agenda statements to set out the form the interview will take (beyond her first question).

Speakers always have available a range of alternative ways of saying things and consequently make choices about the activities to be accomplished in a turn at talk (Drew and Heritage, 1992). Drew and Heritage propose that the action selections made

in turn design, and the selection of how those actions are to be realized in words means that 'issues of turn-design are often highly sensitive to issues of institutional incumbency (p36)'. The interviewer in this talk uses the initial turn of the interview to set up the form it will take. She designs her turn (in part) to set out the form the interview will take through including one or more agenda statements. Although agenda statements are used in everyday conversation, they are used here to set out a particular format to the talk that follows in a similar way to that commented upon by Sacks:

> There may well be some basis for announcing that a joke or story is forthcoming, as a way of telling persons how to listen to the stream of speech one will next produce; where the usual procedure is not to be applied in this case, but another well-known procedure is to be used. (1992: LC1: 683)

6.4.1 Summary

The interviewer uses agenda statements to set out the turn-taking system the interview will take. She may use an agenda statement to describe the nature of the current turn, and to project further turns (in which 'specific' questions will be asked). The projection of 'questions' as interviewer's actions contributes to setting up institutional identities for participants in the talk. IR will ask questions, and it is expected (though not taken for granted) that IE will answer them.

6.5 Discussion

Oakley (1981) has described the way in which interview texts set out to produce 'unbiased' interview responses, and which she finds to be misguided and problematic for those carrying out social research. She argues against 'prescribed interviewing practice' (p41), and states that personal involvement is a necessary condition for carrying out research interviews, which requires:

> ... that the mythology of 'hygienic' research with its accompanying mystification of the researcher and the researched as objective instruments of data production be replaced by the recognition that personal involvement is more than dangerous bias – it is the condition under which people come to know each other and to admit others into their lives (Oakley, 1981: 58).

Further, Oakley comments that few sociologists describe in detail the interviewing process. Oakley's critique brings into play both the need to consider research interviews in relation to how they are produced locally as social events, and the broader social context in which 'data' is collected and in which relationships between interview participants are developed. It draws attention to how such 'personal involvement' might look in interactional terms, and how such relationships are produced. The interviews here are qualitative and about an ostensibly sensitive topic (death of a spouse). Such interviews would appear to fit well with Oakley's call for 'personal involvement' between the interview participants. As such they are a useful basis for considering her comments about research interviewing.

Despite the considerable interactional work that goes into achieving a research interview, only part of it will usually be treated as data[119]. This chapter has started to examine the way in which interview openings are set up and oriented to by participants, by focusing on the setting up of the interviewer's opening turn. Analysis of the interview openings has demonstrated how IR and IE collaboratively work to set up the interview, moving from 'small talk' to a 'formal' interview opening. The roles and identities of 'interviewer' and 'interviewee' are set up prior to the opening of the interview, with participants orienting to the interview as an institutional occasion. This is done through attention to the physical context of the interview, and setting up a turn-taking system where a space is provided for IR to 'open' the interview. Both participants are seen on occasion to prepare the ground for the interview to take place. This may include checking by one or other participant that the physical environment is suitably prepared, e.g. that the tape recorder is set up properly. Although both participants orient to separate roles, they also orient to a joint role of achieving the interview opening. At this stage of the interview (moving into IR's 'opening' turn) both participants orient to the production of interviewing conventions, which could be seen in

[119] This is of course not the case in ethnography where interviews may be conducted as part of broader observational work. However, although researchers such as Glaser and Strauss (1965; 1967) describe 'grounded theory' studies as involving observation and interview, relatively few studies appear to use both methods these days.

some senses as a prescription. However, to address Oakley's concern, the prescription is a joint one rather than being set out by the interviewer.

Entering the opening turn of the interview, the interviewer orients to the request for the story of the interviewee's spouse as a potentially sensitive topic. Her use of preliminaries in relation to the request marks it up as a delicate issue. This appears to reflect an orientation to the delicate negotiations required of interviewers discussed by Ackroyd and Hughes (1992). However, because of the potential sensitivity of the topic (death of a spouse), IR is seen to frame the request as something which is not to be heard as personal to the IE, in the sense that this is particular to them. She makes it clear on occasion that this type of interaction is something she frequently does, asking the same sorts of questions. Marking the story request as something which is 'nothing personal' appears to be used as a way of treating the request as delicate. It works to produce the request as something 'ordinary'. As Sacks (1992) comments:

> A kind of remarkable thing is how, in ordinary conversation, in reporting some event, people report what we might see to be not what happened, but the ordinariness of what happened (LC2: p216).

This sheds some light on Oakley's concern about personal involvement. Oakley provides a limited description of what it might mean in practice, but does imply that it is about setting up relationships with interviewees in which 'personal' experiences are discussed or shared. One way of forming the relationship between IR and IE here is to establish the discussion as something 'ordinary' within the context of doing these interviews. However, rather than making the interview seem 'impersonal' or 'hygienic' (to use Oakley's term), it appears to be used as a cautious device to put the interviewee at ease. It is therefore important to consider the way in which such relationships might be locally situated as personal, hygienic or otherwise. Informing IE that this is nothing personal may in fact be a way of being personal. It will depend upon its use in practice.

The following chapter will explore interviewee responses and will discuss the implications of the analysis of the collaborative production of interview openings in more detail.

CHAPTER SEVEN

THE OPENING TURNS: FINDING THE 'STORY'

7.1 Introduction

This chapter follows on directly from the previous chapter, focusing on how interviewees respond to the interviewer's opening request for the story of the death of their spouse. In Chapter Six, participants were seen to formally set up the start of the interview through their use of sequential resources. The way in which IR cautiously makes the request produces it as a delicate issue (for her). This chapter examines interviewee responses to the interviewer's initial opening request. It is about collaboratively producing the story for the purpose of the interview and takes up Sacks's (1992) point:

> Is there some procedure *people use* which has as its product a showing that they heard and understood? (LC2: 30).

Interviewees generally respond to the opening request in one of two ways, by beginning the story immediately, or by querying where the story should begin. There are exceptions to this, which will also be discussed. It was seen earlier, in Chapter Three (Extract 3.3, page 72), how descriptions are produced by interviewees as stories, and that the recognition that a story is being ventured is used to produce criticisms of health professionals. Before beginning the data analysis let us briefly consider the relevance of Sacks's work on storytelling to the present analysis (of interview openings).

7.1.1 Telling a story

Sacks (1992) shows how, when stories get told in conversation, both storyteller and listener look for and find particular stories with characters and topics. What is eligible to be mentioned in stories has interactional considerations in that what is 'storyable' in one conversation may not be so in the next. Recognition of a story by both participants is key, as what might be recognisable as a story in one context may not be in another.

> What we want to find are some features that have been put into it which provide for its recognizability as 'a story'. We want, then, some features that are not just there incidentally, carried-along artifacts of its being a story, but features that are put in, in the making of a story. (Sacks, 1992: LC2: 18)

In everyday conversation storytellers may 'announce' that they are going to tell a story. This enables them to gain and hold the floor over a number of turns in order to tell the story (Sacks, 1992: LC2: 19). It was seen in the previous chapter that the roles of interviewer and interviewee are established in the opening turns of the interview. The interviewer requests a story, meaning that a multi-unit turn is set up for the storyteller (IE) by the person who will listen to the story (IR). This allows IE to carry on over more than one turn. In everyday conversation, the teller uses a procedure to tell the story, 'They take the teller's status in the story, seek to find a story in which they are just such a person, and then tell that story' (Sacks, 1992; LC2: 30). The listener also uses a procedure to show that they have heard and understood. The procedures used by participants in these interviews differ from those used in everyday conversation, and are explored here.

Sacks's examination of how stories are told in conversation raises some useful points in exploring how stories are told in interview data. As with Sacks, the aim here is to see what is made relevant by the interview participants, to find some procedure participants use and characterise it:

> A sort of orderliness, then, is not just that it takes more than an utterance to do, i.e., more than two people talk in its course, but that's specifically intended by the teller and collaborated in by the recipient. Which is to say that the recipient's talk at various places in the story is talk that deals with recognition that a story is being told. (Sacks, 1992: LC2: 227)

7.2 Interviewee responses: finding the story

The story invitations produced by IR generally take the form: 'tell me the story of what happened'. In a minority of cases the more direct form, 'tell me the story of your husband/wife's death' (Interviews 8, 12) is used. Both forms of invitation indicate that there is a particular story to be told, 'the' story. The way in which the request can be heard is taken up by the interviewees in their responses. The way interviewees respond

will initially be considered in relation to two extracts below, which are relatively straightforward question-answer (Q-A) sequences[120].

Extract 7.1 (Interview 27)

1	IR	( ) erm (0.2) what I do is as a first question I ask is erm (.) quite an open
2		one can you tell me story of what happened (.)
3	IE →	Yes=
4	IR	=and then I go on that gives me an idea (.) and then I go on to more specific
5		qu[estions
6	IE →	[Yes (.) well first of all what happened was that (0.2) er (.) she hadn't been
7		(0.2) she hadn't been well for (0.4) oh (0.4) nearly ten years I suppose but (.)
8		nothing (0.3) specific (0.2) er you couldn't pinpoint it down

Extract 7.2 (Interview 29)

1	IR	You have told me have told me a bit of this hhh. Could could you tell me the
2		story of what happened and [then I can ( )
3	IE →	[yes well er to start with for uhm at least I think
4	→	about say two years (.) [before
5	IR	[mhmm
6	IE	they discovered it uhm he's had er he was having trouble with erm (0.2)
7		swallowing [and breathing hhh.and er:::m they said well when he went to
8	IR	[right
9	IE	((names)) hospital they first put him into the heart department

In Extract 7.1, IE starts to respond to IR's request with a 'yes', indicating that they have heard and understood what the request is about, and will respond. IR then carries on her turn, adding two post-sequences (explaining the reason she is requesting a story, and setting out the interview agenda). In Extract 7.2, IE comes in before IR finishes speaking with a response to IR's request on lines 1-2[121]. He begins this with 'yes well'.

[120] Q-A sequences are referred to by Sacks (1992; LC1: 264) as following the 'chaining rule'. This means that in conversations involving two people, if one person asks a (complete) question, the other person speaks and offers an answer. The chaining rule is commonly used in professional-client settings such as doctor-patient consultations, and counselling interviews (Silverman, 1997).

[121] IE is responding here to the request 'could you tell me the story'. IR's post-sequence about future questions appears not to be a concern for IE but is for IR.

Sacks et al. (1974: 719) refer to these as 'appositional beginnings', which are 'turn-entry devices or PRE-STARTS'. They are common in conversation and can be used for doing beginnings, but do so without the speaker needing to have a plan available as a condition for starting. The use of these appositional beginnings is common in this data. Most of the IE responses are started with 'yes', 'yes well', 'well', or 'yeah'[122]. The appositional beginnings work to preface the story, indicating that the speaker has heard that a response is required from them. They set up the IE's response as contingent on IR's request[123].

In both extracts after the appositional beginning, IE produces a story preface, stating that the story will start at a particular point, 'first of all what happened was' (Extract 7.1), 'to

[122] A breakdown of the use of the appositional beginnings by the interviewees at the start of their responses to IR's requests can be seen in Appendix 4 (page 323). Of the 25 interview openings examined, 17 began with 'yes', 'yes well', 'well', or 'yeah'. Of the eight that began with a different utterance, seven involved 'insertion sequences'. Insertion sequences will be discussed in section 7.2.2.

[123] The story requests, including the pre- and post-sequencing work done by IR are generally heard by the interviewees as requiring an acknowledgement in the form of an appositional beginning. In several of the interviews, the interviewees begin their stories with 'yes' or 'yes well' after the story invitation, overlapping with IR's post-sequences. There is one exception to this, where IE hears IR's request to ask a question as exactly that. She says 'yes fine' on line 11, then waits for IR to ask the question she has asked if she can make. IR then has to prompt her to start her story.

Interview 17

1	IR	This sort of thing [have you (0.2)
		[((paper shuffling sounds))
2	IE	No I had this cough a few weeks ago (0.4)
3		then it went and then (.) last night about el no (.) about half past eleven it
4		started again
5	IR →	Oh right ( ) so: (.) so really what we're going to do and you started
6	IE	to to talk to me about this was ask an open question like could you tell me the
7		story of what happened (0.2)
8	IE	M[hm
9	IR	[Erm with your husband (.) and then go on to more specific (.) questions
10		about the care and that sort of thing (.) so is it alright to=
11	IE →	=Yes fine (.)
12	IR	=you know to [( )
13	IE	[Fine (0.2) fine erm (1.0)
14	IR →	Whenever you're ready=
15	IE	=Oh right= (0.2)
16	IR	=yeah (.)
17	IE	Erm (0.2) well he suffered (.) he had TB (.) twenty (0.4) twenty (0.2) I dunno
18		(0.3) I've been married 50 years haven't I (.) twenty three years ago he
19		contacted TB (.) he worked in the erm (0.2) the power station

start with' (Extract 7.2). They then produce a chronological marker, 'she hadn't been well for (0.4) nearly ten years I suppose' (Extract 7.1), 'at least I think about two years' (Extract 7.2). The interviewees select a place to begin their story, but produce them as approximations, adding 'I suppose', and 'I think' to the chronological markers. This indicates that interviewees consider accuracy to be a consideration in their stories, and using approximations avoids possible charges of inaccuracy by IR. The way in which interviewees 'search' for accuracy in their stories will be considered again shortly.

In the extracts above we can see that participants produce and orient to a sequence with IR producing a request, and IE responding. In shorthand this can be represented as a question-answer (Q-A) sequence. The Q-A sequence is a type of adjacency pair (Sacks, 1992; Schegloff, 1972), which is used to organise talk so that something (Q) goes first and something goes second (A). It sets up a turn taking system related to the order of speakers. In the previous chapter, it was seen how once IR takes her 'opening' turn, she produces a request which sets up a turn for IE to speak. Adjacency pairs are used 'at key points in the overall structural organization of conversation' (Sacks, 1992; LC2: 522). They are 'two utterances long, adjacently placed, have various names, a relative ordering of parts, and a discriminative relationship for the parts' (Sacks, 1992; LC2: 527). All the interview openings are organised upon the Q-A adjacency pair format. However, only 10 out of the 25 interview openings analysed involve a straightforward Q-A sequence[124].

7.2.1 Making a query: using insertion sequences

In a number of the interview openings the interviewee takes up a query with the interviewer, asking a question as to where the story should start. IR has to respond to this before IE can produce their response to IR's request. The way in which interview participants manage interruptions to the Q-A sequence is considered in relation to the extracts below.

[124] The 'distribution' of types of interview openings can be seen in the table in Appendix 5 (page 324).

Extract 7.3 (Interview 15)

1 IR Fine [I've got (.) I've got everything I might need stuff like that (0.2) so I you
2 IE [( )
3 IR were going to tell me no I don't know the story of (0.2) of what happened=
4 IE → =oh erm (.) well shall I start from the beginning?=
5 IR = Yes (.) if that's OK (0.2)
6 IE My wife had breast cancer (.) she had a breast removed about 15 years ago (.)
7 IR mhm (0.4)
8 IE which was (.) when huh (0.2) about 70s maybe (.) 80 (0.6) 81 then something
9 like that wasn't it (0.2) 1981 (0.8) and er (.) she (0.2) got over that

Extract 7.4 (Interview 22)

1 IR story of what happe:ned (0.2) and then I go on and ask more specific questions
2 that gives me a kind of general pict[ure (.) of what happened ( )
3 IE→ [What happened in the beginning do you
4 mean? (.)
5 IR Yes (.) well (.) wherever you'd like to start (0.2)
6 IE Well the beginning's usually a good place isn't it heh [heh
7 IR [Yes that's right=
8 IE =erm (0.2) well ((names wife)) used to teach yoga she went off one night to the yoga class she
9 had a very bad pain in her shoulder

The queries take the form of insertion sequences and interrupt but do not disrupt the Q-A sequence. An adjacency pair can be interrupted by an insertion sequence, so there might be a Q [q-a] A turn format happening instead (Sacks, 1992; Schegloff, 1972). Insertion sequences occur in Q-A sequences when another question-answer sequence is inserted between an initial question and its answer. The work that insertion sequences do is raised by Schegloff:

> How are insertion sequences in Q-A pairs possible without a violation thereby being committed, without the absence of an answer being found – that is, how do people see when a question follows a question that it is not any other question, not an evasion? (1972: 114)

In the two extracts above the interviewee interrupts the Q-A sequence with a query, 'well shall I start from the beginning' (Extract 7.3), 'what happened in the beginning do you mean?' (Extract 7.4). In Extract 7.3 IR responds with 'yes', adding a post-sequence 'if that's OK'. IE does not hear 'if that's OK' as something he should respond directly to but rather as an agreement that this is where the story should begin. He does not use another 'well' preface, but starts his story straight away with a description of his wife's breast cancer. The full story request has not been recorded so the format differs from that seen in earlier extracts. However, given the nature of adjacency pairs, IE's response querying where his story should begin indicates that he hears IR's utterance on lines 2-3, 'you were going to tell me no I don't know the story of (0.2) what happened', as the end of a request.

Schegloff (1972) argues that in some instances at least, the Q-A insertion sequence is a pre-sequence for the activity of the answer, so that when it is produced the answer to the initial question becomes conditionally relevant.

> Where the one who is to give directions (regarding the location of a place) does not have the materials for the required analyses, or seems not to have them, the possibility of asking for them becomes relevant, and a pre-sequence can be a way of doing that and can be seen to be doing that. (Schegloff, 1972: 110)

The insertion sequence does not interrupt the main Q-A sequence, producing instead a modified form, Q [q-a] A.

In Extract 7.4, the sequence is slightly more complex. IE raises his query on line 3, which IR responds to by putting the decision back to IE, 'wherever you'd like to start'. IR's response contributes to setting up the story invitation as a form of open-ended interviewing, indicating that there is not a set response she expects to hear[125]. However, instead of going straight into the story as IE does in Extract 7.3, the interviewee produces a response in the form of a question which results in the interviewee laughing

[125] This is in line with Rapley's (2001b) analysis of qualitative interviews where it was found that interviewers routinely construct themselves as 'animators' (p200) who are both neutral and facilitative.

and IR producing an agreement. As with Extract 7.3, this does not interrupt the Q-A sequence but produces a version of that sequence, Q [q-a q-a] A.

7.3 Story 'beginnings'

In extracts 7.3 and 7.4, IE suggests a place where the story could begin and checks it out with IR. In suggesting that 'the beginning' is a possible place to start, the interviewees demonstrate access to 'a beginning', and other possible places where the story could start. There is a beginning to the story, but this is not necessarily where the story produced for the purposes of the interview will start. A particular story is therefore selected and recounted, in collaboration with IR. As Schegloff (1972) comments:

> ...if one looks to the places in conversation where an object (including persons) or activity is identified (or as I shall call it, "formulated"), then one can notice that there is a set of alternative formulations for each such object or activity...'. (p80)

The way in which the interviewee uses the insertion sequence to 'find' the 'right' story demonstrates their orientation to the requirement of the interview context. This is the case with IR too as she orients to the stated nature of their request as 'open' (see Chapter Six), by telling IE that the decision as to where the story should begin is for them to make. The query raised by IE in the insertion sequence also contributes to setting up IR's role as someone who knows what is required for the interview. They have asked a question so they require a particular type of answer[126]. The insertion sequence is therefore used by both participants to define the 'topic', or content of the talk, as described by Schegloff (1972):

> ...in their co-selection they, at least in part, "constitute" the topic. (p80)

[126] Qualitative research texts generally include chapters on interviewing which aim to inform would-be interviewers how to gain and manage the information they require on their topic of interest (for example, see Denzin, 1989; Mason, 1996, 2001). What is of interest here regarding this is the way that interviewees work to produce the 'right' information too.

> Since the insertion sequence is specifically done and heard as prefatory to the activity made conditionally relevant by the question, attention both to that activity and to the question is thereby exhibited. (p114)

The interviewees orient to the Q-A sequence, taking up their turns at this point and responding to the story invitation.

The data discussed so far involves fairly straightforward interview openings, which take one of two formats, either the straight Q-A format, or one where the interviewee makes a query about where to start (Q-q-a-A). The queries usually include a suggested starting place by IE, so IR just has to agree. They indicate that IE has searched for and found a possible story. As it is being produced for a particular purpose, the interview, IE checks if this is the story the interviewer is expecting to hear, or the right story. This is in line with Schegloff's (1972) argument about selecting a (geographical) location for a story, that there will be a set of terms or formulations that are 'correct' (p114). This means that speakers generally select 'right' or adequate formulations, and do preliminary work if it is required in order to do so. In this way, participants in talk 'analyze context and use the product of their analysis in producing their interaction' (Schegloff, 1972: 115).

7.3.1 Story specifics

A number of the interview openings differ from the formats discussed so far, in that an insertion sequence is initiated by IE but it is used to raise a query other than 'shall I start at the beginning?'. The basic Q-q-a-A sequence remains intact, but the way the story is selected is different. This will be considered initially in relation to Extract 7.5 below, where IE introduces an insertion sequence that differs from those discussed so far in that he raises a concern about being unable to remember dates.

Extract 7.5 (Interview 26)

1 IR sort of I start off with an (.) quite an open question like could you tell me the
2 story of what happened (.)
3 IE Mhmm=
4 IR =then that gives me a picture (.) and then ((cough cough)) ooh ( ) coughing and
5 then I go onto more specific questions a[bout sort of ins and outs of the care that
6 IE [mmm
7 IR you received and that sort of [thing hhh. so can I (.) [could you tell me the story
8 IE [mhmm [( )]
9 IR of what happened=
10 IE =Well [erm
11 IR [I know you've told me a little bit anyway=
12 IE → =the only thing is at the moment I cannot the the only date I can actually
13 remember ( ) is the day ((names wife)) died [and the time hhh. erm the rest of it erm (0.2)
14 IR [yeah ( )
15 IE I I (.) you know (.) I can't even remem[ber now what month (0.2) things
16 IR [mmhm
17 IE happened=
18 IR =no=
19 IE =or any dates I mean obviously you'd have to get them from er (0.2) ((names hospice))
20 could tell you the dates she was in there and er (0.2) ((names hospital))=
21 IR =when when I start when you start telling me I can work out (.) roughly [certain
22 IE [yeah
23 IR things anyway but we [we don't want exact dates or any[thing to be honest=
24 IE [but [oh no
25 IE =anyway I know I know erm I know its eight months now since she died isn't it

Rather than querying where the start of the interview should be, IE raises an issue about dates on line 12. This shows that he is orienting to a story requirement that involves him giving specific dates of the events to be included in it. He hears IR's request on line 1 'I start off with an (.) quite an open question like could you tell me the story of what happened', as a request for a story which requires specific dates (even though IR does not mention dates). Attention to the accuracy of dates and times was seen earlier in extracts 7.1 and 7.2, where the interviewees use prefaces to produce approximate times, 'nearly ten years I suppose' (Extract 7.1), 'I think about say two years before' (Extract

7.2). They treat the lack of specificity of chronological times and dates as something to be attended to. This does not happen in all the cases but does show that, as Sacks (1992) demonstrates, storytellers look for a particular story to tell to a particular audience[127]. Here these interviewees work to produce a particular story with boundaries even though the question is apparently open-ended and it is up to them to decide what is in it[128].

In Extract 7.5 the issue raised by IE about dates (line 12) is responded to as a query or request for reassurance. IR comes in on line 21, saying that she will be able to work it out, and that she is not expecting exact dates. Both participants are orienting to a story that has a chronological beginning. The story topic and starting point are negotiated.

In the previous extract (7.4), IE looks for and finds a possible start for his story, 'What happened in the beginning do you mean?', but queries with IR whether this is what she would like to hear. In the interview openings that included an insertion sequence dealing with where the story is to begin, there were a number of cases in which IE raises a query with IR about other story selection criteria. The story topic is queried in two cases. One is where IE asks if the story should be about his wife. The other is where IE asks if IR means her husband's job. In another case IE just asks IR what she means by her question.

[127] In these interview accounts storytellers are orienting to an audience interested in assessments of health care experience.

[128] The interviewee's reference to being specific about dates raises a potential problem with his account, in advance. It indicates that he is working at being a 'reasonable' informant (see Chapter Two). He also indicates that, as with IR, he has a pre-set agenda relating to what is expected of him in the interview. However, he does not state it directly through an agenda statement as IR does.

Extract 7.6 (Interview 24)

1 IR an op:en (.) question at the beginning (.) and then go on to more specific
2 questions (.) so .hhh I was wondering if you could tell me the story of what
3 happened (0.2)
4 IE→ What ( ) my wife you mean [( )
5 IR [mmm yeah then that gives me a picture of (0.2)
6 IE Well=
7 IR =what went [on
8 IE [she'd been ill for some time like you know with er (.) with this er
9 complaint she had (0.4)

Extract 7.7 (Interview 8)

1 IR Erm (.) so could you (.) my first question is could you tell me the stor:y of (.) of
2 your husband's death and (0.2)
3 IE→ Oh yes[well wha] you mean his job? (0.2)
4 IR [then I'll]
5 IR What whatever wherever you'd like to start=
6 IE =he was this head (.) head groundsman in a sports ground (0.4) and he retired

In Extract 7.6 IE raises a query as to who the story is about, 'What ( ) my wife you mean' (line 4). IR responds with 'mmm yeah' adding a post-sequence explaining why she wants to hear the story about his wife. IE infers that he is selecting a story from a different range of alternatives than the majority of the other interviewees. He makes a possible selection, saying 'my wife you mean', but indicates that the requested story could be about someone else. This also demonstrates his orientation to producing a particular story (which IR wants to hear). He then goes on to start the story itself with the appositional beginning, 'well' on line 6, again indicating that IR's post-sequence which adds some information as to what the story is about, is not required by him to produce the story.

In Extract 7.7, IE introduces an insertion sequence after she starts to provide her response with 'oh yes well'. This can be heard as an acknowledgement of the request for the story. She then comes in with 'wha you mean his job?'. This is both a possible topic for the story and a place for it to start. IR hears it as a suggested place to start the

story, saying 'wherever you'd like to start' (line 5). As with Extract 7.4 above, she gives IE the responsibility for deciding the structure and content of the story. In this way IR works to achieve neutrality in her role as interviewer (Rapley, 2001b). IE then goes on to start her story. The analysis demonstrates that responses to open questions are negotiated and set up collaboratively. This means that both participants engage in producing the particular story that gets told.

In one of the interviews IE makes a direct query about the meaning of the question. This can be seen in Extract 7.8 below, where IE asks outright what IR means by the question. This differs from the other queries by interviewees, in that no suggestions are made by her as to where the story might begin, or what it should be about.

Extract 7.8 (Interview 18)

1	IR	Ri:ght (.) so I was going to say can you tell me the story of what happened (0.4)
2	IE	what do you mean? (0.2)
3	IR	Erm sort of from where it began really you did start to (0.4) to tell me (0.2)
4	IE	Well I suppose it just began when he (0.2) when he had this erm (0.2) dropped
5		foot (.)
6	IR	Right (.)
7	IE	He must have begun to feel his erm (0.4) the loss of (.) power a bit in it then he
8		went to the doctor

IE says 'what do you mean?' on line 2, indicating that she does not understand the question at all. IR responds with 'where it began', helping IE a bit by adding a post-sequence 'you did start to (0.4) to tell me'. IR uses the course-of-action device (see Chapter Four) to direct IE to tell the story she had started to tell before the interview formally began. This shows that the distinction between interview and pre-interview talk is not clear-cut. Talk produced in one context (the pre-interview) may also be required in another (the interview). It also helps to constitute the difference between the pre-interview talk and the interview talk. This may involve IE repeating something she knows IR has already heard. The way this is managed by participants will be considered in Section 7.4 below.

7.3.2 Summary

Following on from the opening turn by the interviewer, interviewees look for and find the requested story. This is found relatively easily and provided through the Q-A format, or it can include an insertion sequence. The insertion sequence does not disrupt the Q-A sequence. When queries are raised by interviewees through insertion sequences, they primarily take the form of negotiating where the story should begin, with the interviewee suggesting possible beginnings. There are some exceptions to this where the topic of the story is checked out with IR. A topic is either set up by IE, or suggested to IR who agrees. In all but one of the cases discussed so far, they look for and find a story to tell. The way in which the story is searched for and selected indicates that, despite the question being 'open', both participants are orienting to producing a particular story for the interview. They set up and orient to the local context. There are other possible stories that could be produced, starting in different places, and about different but related topics.

7.4 Attending to the possibility of repetition

In Extract 7.8 above IR refers to IE having already started to tell the story prior to the interview beginning. This means that pre-interview talk may include information that is relevant to the (formal) interview. This raises the possibility of the interviewee repeating of what has already been said. This situation is potentially problematic and needs to be managed by the interview participants, particularly IR. This will be discussed in relation to three extracts. The first two are presented initially below.

Extract 7.9 (Interview 29)

1 IR → You have told me have told me a bit of this hhh. could could you tell me the
2 story of what happened and [then I can ( )
3 IE [yes well er to start with for uhm at least I think
4 about say two years (.) [before
5 IR [mhmm
6 IE they discovered it uhm he's had er he was having trouble with erm (0.2)
7 swallowing [and breathing hhh.and er:::m they said well when he went to
8 IR [right
9 IE ((names)) hospital they first put him into the heart department

Extract 7.10 (Interview 3)

1 IR You know the services you recei:ved and what hap some of it actually you've
2 Already told me [so I can make a note of it but erm=
3 IE [mhm
4 IE→ =oh right (0.2) am I on? (.)
5 IR Yeah you're on (.) but don't worry heh heh heh heh hhh. you don't heh I your
6 name isn't on it or anything like that [and no-one will know its you and I lock
7 IE [No
8 IR them away and then we're going to I just put (.) I've got a code number you
9 you see=
10 IE =Oh I see
11 IR and erm (0.2) I ju I lock them away in a cupboard and we'll (.) we'll we'll erm
12 (0.2) destroy them when peop when we've finished the study or whatever (0.2)
13 yeah cause you said it (0.2) you started to tell me how it (.)
14 IE Now he started off with er (.) an ingrowing toe nail=
15 IR =mmh

In Extract 7.9 IR includes a pre-sequence 'you have told me have told me a bit of this' before her story invitation. She indicates that she has already partially heard the story, 'this'. The pre-sequence can be heard in two ways, as a way of highlighting the possibility that some of 'the story' may involve repetition of what she has already heard, or that she requires more detail. Saying that she has heard some of 'this' before infers that she expects to hear some information she has already heard (even if it is used as a

basis for adding the detail). In this way she is ambiguous about what the story may contain.

A similar approach is initially taken in Extract 7.10. Only the tail end of IR's opening turn is recorded but she is heard to make a similar utterance to that in Extract 7.9, 'some of it actually you've already told me'. This time it is included as a post-sequence. However, in this instance IR adds another post-sequence 'so I can make a note of it'. Unlike Extract 7.9 this indicates that she will take separate account of what she has already heard. After an insertion sequence dealing with a query by IE in lines 3-12, IR picks this up again with a prompt for IE to carry on with what she has already heard. In both cases IR attends to the possibility that she has heard part of the story that IE will tell. IR states that she has heard 'some of it' and 'part of this', but not all of it. She is stating that she has been listening to what the interviewees have been saying and has taken what she has heard into account. Marking up the possibility of repetition pre-empts a possible charge that she is asking IE to repeat what they have already said and what she has already heard.

Following IR's opening turn the interviewees begin their responses in a similar way, 'to start with' (Extract 7.9) and 'he started off with' (Extract 7.10). These responses indicate that the interviewees hear IR's statement about having already heard some of the story as a way of managing the possibility of repetition in their stories rather than as a request to tell their story in a particular way, e.g. through omitting the parts they have already described. This will be discussed further in Section 7.5 in relation to a deviant case.

If IR does not mark up the possibility that responding to the request for a story may involve repeating what has already been said, it may be remarked upon as odd by the hearer. This can be seen in Extract 7.11 below.

Extract 7.11 (Interview 5)

1 IR	Could you tell me the story of what happened (0.2)
2 IE →	You've just read it in there [heh he was yeah he was [diagnosed=
3 IR →	[I know I have
4 IR	=just brie[fly
5 IE	[erm about two years before he died=
6 IR	=Right (0.3)
7 IE	that was a great big shock because we went down to the ((names health centre)) (.) just for the
8	result of the X-ray (.) he hadn't got any pain or anything like that (0.3)

In this extract IR requests a story, setting out the task for IE without adding a pre- or post-sequence marking up the possibility of repetition. IE immediately responds with 'you've just read it there', indicating that this would be repetition and implying that 'the story' is what IR has just read[129]. IR already has the information so it is to be remarked upon that she wants to have the information again. Her comment marks it as odd that IR has asked her to repeat the task, even though the information was conveyed through a written document rather than orally. IR has made no attempt to pre-empt this as a possible charge, which she does in extracts 7.9 and 7.10. The interviewee does not mark it up as odd in either of those extracts, as IR has pre-empted the likely reaction in her request.

In Extract 7.11 IE does not wait for an explanation from IR but laughs, which works to diffuse the awkwardness of this situation, before carrying straight on to the requested story. IR comes in with overlapping talk on line 3 acknowledging that she has read the document IE is referring to, but offers no explanation, only saying 'just briefly' on line 4[130]. We can take the way in which IE goes straight on to the requested task of the story as an indication that she accepts that this is part of the requirement of the interview.

Requesting that someone repeat something they have just heard is not usual in everyday conversation. As Sacks comments, 'there's a major sort of norm against repeating the same thing to the same person' (Sacks, 1992; LC2: 21). If this does happen it is usually

[129] IE has given IR a note to read detailing the events.

[130] If she had heard 'you've just read it there' as a charge we would expect a sequence of charge – excuse – assessment of excuse.

because the person speaking does not notice that they are repeating what they have just said to the same person. However, as seen in this extract, there are situations when repetition is required. This suggests that there is a special reason for doing it. So, to tell someone something you have told them before is to do something special (Sacks, 1992; LC2: 21). Here we have a situation where repetition is in some instances explicitly required, or where the possibility of repetition needs to be attended to. The issue of repetition needs to be managed by the person who requires it, the interviewer.

The story is being produced for a particular purpose. Repetition is therefore 'allowed' here so that the research interview can be achieved. IR does not say directly that she expects repetition in extracts 7.9 and 7.10. She uses ambiguity in the way she marks the possibility that it might occur. Stating that she has already heard some of the story, or 'this', makes it allowable in these particular circumstances.

7.4.1 Summary

In all of these extracts, either IR (7.9 and 7.10) or IE (7.11) explicitly attend to Sacks's conversational norm of non-repetition. The work done by participants in attending to repetition in the interview openings shows that they both monitor the reception of their talk. In extracts 7.9 and 7.10 IR states that she has already heard some of what she may hear in the story. In Extract 7.11 IR is charged with having already been given the story. This charge is possible because she did not attend to the possibility of repetition in her opening turn. Comments in all three extracts (by the interviewer in extracts 7.9 and 7.10 and the interviewee in 7.11) about the interviewer having already heard part of the story invoke the wider social context in which the interview talk is taking place. The interviewees have already imparted part of the story, but in a prior context with a different range of contextual constraints. In these cases both the interviewer and interviewee at times make previous talk relevant and procedurally consequential to the task of the current talk.

7.5 Open-ended interviewing: a deviant case

The analysis of how the talk is produced as the interview has highlighted two key patterns in the way the requested story is found. The following formats occur in all but one of the 25 interview openings:

- IR requests the story then IE begins their story (Q-A sequence); or
- IE makes a query about the content of the story, such as where to begin (Q-q-a-A sequence).

The interviewees are seen to find beginnings to their stories, though they may sometimes check whether the story they have 'found' is the one that IR wants. It was seen in the second format how, when there are queries, IR works at being 'facilitative and neutral' (Rapley, 2001b), leaving the start of the story up to IE. This works well in all but one case. In this interview IE begins her response to IR's request without making a query. However, this is not heard as the story required by IR, and she interrupts to put IE 'on track'. In this sense Extract 7.12 is a deviant case.

Extract 7.12 (Interview 16)

1	IR	Could you tell me the story of what happened (.) which in a way you've kind of
2		told me now=
3	IE →	=Yeah (.) oh yeah (0.2) yeah (.) I was surprised you know (0.2) couldn't
4		believe it (0.2)
5	IR →	No yeah (0.2) so (0.6) cause cause you (0.2) could you just go over that again
6		briefly that what happened (.) you know sort of the story [of what happened
7	IE	[oh yeah the stor as it
8	IR	would that be alright]
9	IE	began yeah yeah yeah] well we went to Turkey=
10	IR	=yeah (0.2)
11	IE	for a holiday (.)
12	IR	yeah (0.2)
13	IE	and er (0.4) well my wife she just become (.) real (0.2) real down

In this extract IR makes her story request and similarly to extracts 7.9 and 7.10 makes a reference to the possibility of IE repeating what she has said. However, this time she indicates that IE has already told her the story, 'which in a way you've kind of told me now' (line 1). She acknowledges that she has heard the whole story, but downgrades it to, 'kind of told me'. This leaves open the possibility that she may not have heard it all. IE does not come in with a story beginning, or a query about where to start. After three 'yeahs' on line 3, he says 'I was surprised you know (0.2) couldn't believe it', which is a comment on his reaction to the events already recounted to IR. It indicates that he hears IE's request and post-sequence as being about building on what he has already said, rather than repeating it.

IR comes in after a short pause with a non-specific sequence 'no yeah (0.2) so (0.6) cause cause' before repeating the story request, specifically asking IE to retell the story (line 6). The initial part of IR's response indicates that she does not hear what IE has just said as the type of response she wants but does not have an immediate solution available. She then repeats the story request. IE acknowledges their understanding of the request with 'oh yeah' and then stating what he takes the request to mean, 'the stor as it began'. After three 'yeahs', IE produces a story beginning similar to the other interviewees, 'well we went to Turkey'.

In repeating the initial question, IR indicates that she does not recognise IE's response as a story. This is in line with Sacks's comment, 'that one is 'telling a story' is an important thing for others to recognize' (1992; LC2: 18). Unlike other Q-A formats discussed, which can include an insertion sequence from IE without disruption, the format here is different. IR interrupts IE's answer and stops it. She then repeats her initial request. This produces the sequence, Q-A-interruption/stop-Q-A sequence.

The work that IR does to get IE to produce a different response from the one he makes tells us something about her efforts in other interview openings to be 'neutral' and elicit an open-ended response from an apparently 'open' question. This interview deviates from the others. Elsewhere she ostensibly gives the responsibility for deciding where to

start the story to IE, using ambiguity to mark the possibility of repetition, but here IE starts to produce a story or response IR does not expect or want. IR actively interrupts and guides IE to tell the story she would like, which is a repetition of what she has already heard. This demonstrates that there is a particular story required. The responses to the question 'tell me the story' are therefore clearly monitored by IR. Analysis of this extract supports the norm developed in earlier analysis, that the responses to the open question asked by IR for a story are collaboratively set up and oriented to as such by both participants. They both work to produce and select the story that gets told.

Open-ended interviews or questioning clearly do not mean that anything goes. The stories produced are particular stories constructed for the purposes of the interview. They are set up and oriented to as such by both the interviewees and the interviewer as shown in the data examined above. It can be seen in the way that interviewees will generally query what their story should look like if they are unsure, and in the way that the interviewer in Extract 7.16 intervenes if the 'proper' story is not told[131].

7.6 Discussion

Chapters Six and Seven examine how the interview is constructed as a particular form of social interaction, with participants setting up their roles as interviewer and interviewee in the opening turns. Sequential analysis of the data has highlighted a number of issues relevant to establishing the status of interview accounts which can be considered in relation to a more conventional approach.

As discussed in Chapter One, the qualitative interview is a popular research method in sociology and health. However, the many texts available on how to do interview research tend to emphasise how the interviewer can best elicit the information required

[131] This is interesting on a personal level as an interviewer. As discussed in Chapter Two, I worked at being a neutral interviewer, trying to say as little as possible as I was aiming at data 'uncontaminated' by me. However, as evidenced here, in attempting to achieve this I was orienting to producing data that looked like stories for my analysis.

from the interviewee. This approach includes what are ostensibly open-ended interviews, as seen in a recent publication:

> Two principles inform (qualitative) research interviews. First, the questioning should be as open-ended as possible, in order to gain spontaneous information rather than a rehearsed position. Secondly, the questioning techniques should encourage respondents to communicate their underlying attitudes, beliefs and values, rather than a glib or easy answer. The objective is that the discussion should be as frank as possible. (Fielding and Thomas, 2001: 126)

The interview is viewed as a research tool used by the interviewer. Interviewee responses are to be 'spontaneous' yet should also have a particular form (not 'glib or easy' answers). This can be seen as a conventional approach to the conduct of qualitative interviews. The primary role of the interviewer is to attend to the information the interviewee provides. As Gubrium and Holstein (2002b) comment in their recent critique of interview research:

> ...the information is viewed, in principle, as the uncontaminated contents of the subject's vessel of answers. The knack is to formulate questions and provide an atmosphere conducive to open and undistorted communication between interviewer and respondent. (2002b: 13)

Gubrium and Holstein (2002b) argue further that in many interview studies, the researcher is interested in eliciting views from 'the passive subject behind the respondent' (p13). Within such an approach respondents are viewed as the 'vessels of answers' who possess the information the researcher wants to know. Gubrium and Holstein offer a different approach to interview research which will be discussed towards the end of this chapter.

On one level the analysis of the interview data in Chapters Six and Seven supports the observation made by Gubrium and Holstein regarding qualitative interview research, that interviewers attempt to create an atmosphere conducive to open communication. In qualitative interviews interviewers are cautioned to reduce the likelihood of bias by taking care in the way they ask questions. This can be seen in the way the interviewer responds to queries from interviewees, as seen in the extract below:

Extract 7.13 (part of Extract 7.4 above, Interview 22)

3 IE [What happened in the beginning do you
4 mean? (.)
5 IR Yes (.) well (.) wherever you'd like to start (0.2)

Another way in which the interviewer works to elicit views from respondents in the way Gubrium and Holstein describe is through prefacing work in relation to the story requests. This was examined in Chapter Six, and supports Rapley's analysis which has shown how prefacing is used by interviewers to set up a neutral and facilitative identity:

> Question prefaces can work to display the question for what it is: they inform the interviewee about the talk that follows, and how to respond to it, as well as constructing both speakers' identities in relation to the talk.... Question prefacing can be an *economical way* to inform the interviewee that their questions are to be heard as facilitatory. (2001b: 166)

Through these methods interviewers attempt to do fulfil their role according to the principles described by Fielding and Thomas above. However, the focus of the analysis in Chapters Six and Seven is on the collaborative production of the interview talk which goes beyond attention to the work of either the interviewer or interviewee.

7.6.1 The collaborative production of open-ended questions and responses

The analysis has focused on the work of the interviewer and interviewee separately for practical reasons. When the work of the interviewer and interviewee are considered together the production of the story is seen to be at the same time an open-ended *and* a selected version of events. Sacks (1992; LC2: 227) raises a number of questions regarding storytelling which were discussed in the analysis of criticism in Chapter Three. They can also be usefully be considered here:

- How is it that telling a story is relevant to the talk one does?
- How is recognition that a story is being produced relevant to the hearers?
- Why does the possible fact that a story is being told matter for the telling of it?

In response to the first question it can be seen that the identities of the participants as interviewer and interviewee mean that it becomes the role of the interviewer to ask questions and that of the interviewee to answer. If the interviewer requests a story it therefore follows that it is expected (but not guaranteed) that the interviewee will provide one. Producing a story is a set up as a requirement if the interview is to proceed smoothly. The second and third questions have particular relevance to the participants in the interview openings and will be considered together in the discussion below.

It was shown earlier in this chapter that the interviewees respond to the open-ended request for a story with a particular type of answer. Three forms of response to the interviewer's open-ended question were observed:

- the interviewee starts their response immediately following the request;
- the interviewee makes a query by way of an insertion sequence to clarify where the story should start and/or what it should contain;
- the interviewee starts their response but the interviewer intervenes and guides them to the story she wants to hear.

The first two patterns are prevalent. The third is a deviant case. This patterning demonstrates that in these particular interviews responses to open-ended questions require a proper *beginning*. This is seen in the way the responses are either started with a beginning (which is not contended by the interviewer), or the interviewee makes a query about where to begin. The fact that a story is being told is important because stories have certain features which can be locally negotiated. For example, they can be about different possible topics and can have different possible starting points. The interviewee designs a response that will fit in with the expectations of the interviewer. For example, the use of the insertion sequences to make a query here appear to reinforce the Q-A sequence (and the roles of the interviewer and interviewee) as they are a check that the answer is the required answer rather than any old response. This demonstrates the local contingencies of the interaction which has similarities across occasions, but also differences which are accommodated within the sequential organisation of the talk.

The interviewer works to produce an open-ended question, in an attempt to encourage the spontaneity that Fielding and Thomas suggest. However, the one case in the 25 interviews where the interviewer intervenes to guide the interviewee to the story she expects in response to this question, demonstrates that spontaneity (paradoxically) is a collaboratively managed activity. The interviewer aims for 'neutrality' (cf Rapley, 2001b) while at the same time monitoring the responses given by interviewees to ensure that she gets the type of response she requires. The approach the interviewer takes is in line with the role of professionals in general, who are trained to take a 'neutralistic' stance with respect to the problems they deal with (Bergmann, 1998: 291). However, the achievement of neutrality in these interviews is dependent upon the interviewees producing a response that is recognised by both participants as the right one.

If a neutral approach does not produce the required response it is the responsibility of the interviewer to intervene. This demonstrates how interviewers achieve their task of managing the tension between being neutral and facilitative and gaining the interview data required (cf Rapley, 2001b). The open-ended questions are contingent upon the interviewee producing the answer the interviewer wants to hear. Recognition by both participants that a story is being told is therefore crucial to the success of the interviewer's question (in gaining the right type of open-ended response).

Fielding and Thomas (2001) view this as an interviewer's dilemma. They identify a common problem in qualitative interview research that respondents give answers they 'anticipate the interviewer wants to hear' (p127). However, rather than being viewed as a problem, the way in which interviewees skilfully attend to producing the answers 'the interviewer wants to hear' can be considered as part of the analysis. Qualitative interview accounts, as with all talk, are products of the local interactional contexts in which they are produced. Even in the earlier empirical chapters, which primarily examined the talk of the interviewees, it was seen that accounts are designed both for the recipient and wider audiences (see Chapter Three in particular). Greater recognition needs to be given to the way in which the collaborative production of qualitative interviews helps to get the job done.

In their critique of interview research mentioned earlier in this discussion, Gubrium and Holstein (2002b) draw attention to the way in which both interviewers and interviewees actively produce knowledge. They suggest that both interview participants should be regarded as active rather than passive actors in the production of interviews. Such an approach means that the notion of interviewer neutrality is neither useful or necessary. As Gubrium and Holstein comment:

> ...researcher contributions to the information produced in interviews are not viewed as incidental or immaterial. Nor is interviewer participation considered in terms of contamination. Rather, the subject behind the interviewer is seen as actively and unavoidably engaged in the interactional co-construction of the interview's content (2002b: 15).

The analysis of interview openings discussed in Chapters Six and Seven supports the approach advocated by Gubrium and Holstein. However, through the detailed analysis of how the roles of interviewer and interviewee are set up, it contributes a description of how this is produced sequentially by participants.

PART FOUR: DISCUSSION

This section is a discussion of the implications of the analysis. Three chapters are included. The first, Chapter Eight, reviews how my analysis has developed Baruch's study of interview data. This is developed into a discussion of the status of interview data. The second chapter in this section, Chapter Nine, examines the implications of the analysis for the sociology of health illness, and health policy. An important aspect of this discussion is the study of lay assessment work. A final chapter reviews the limitations of the study and proposes some areas for further research.

CHAPTER EIGHT

THE STATUS OF INTERVIEW ACCOUNTS

8.1 Introduction

This chapter takes up one of the study aims set out at the start of the thesis: to examine the status of qualitative interview accounts. It will discuss the implications of the data analysis for how qualitative interviews are to be treated by researchers. The study began with some qualitative interview data collected on what could be considered to be a 'health and illness' topic (the death of a spouse from cancer). The plan was to analyse the interview materials through the application of ethnomethodological principles, using methods proposed by Harvey Sacks. My analysis has built upon earlier work by Baruch (1981; 1982), who had analysed qualitative interviews with parents of children with medical conditions. Baruch's analytic approach to his interview data was broadly ethnomethodological. Taking account of earlier work by Sacks (1972), and Cuff (1980), he aimed to treat the accounts as situated, rather than as direct representations of external events.

My study of interview data has evolved through a number of analytic stages and seeks to contribute to sociological knowledge about health and illness, interview research, and policy and practice. The three areas studied (criticism, assessments, and interview) are related to one another but each has a separate analytic focus. This chapter and the next consider the analysis as a whole and its implications for researchers, sociologists of health and illness, and policy makers.

When the analysis is considered as a whole, it can be seen that a central activity in the accounts is to produce assessments of health care experience (regarding the terminal illness and death of a spouse). Empirical study of the interviews as the *topic* of analysis rather than as a resource for analysis has demonstrated how the interview participants, in particular the interviewees, set up and use a range of resources to produce their assessments. This includes detailed identity work around lay and professional roles and responsibilities, and the setting up of certain entitlements in the interview accounts, e.g. to state an opinion (as a lay person).

An implication of the analysis is that greater attention needs to be given to the way participants construct interview accounts, both in general and regarding health and illness. This is for two main reasons. The first is that it makes it possible to examine the status of the accounts as set up by the participants[132]. The second reason is that interview accounts are places in which health and illness exist and therefore in themselves warrant greater understanding. The first point, the status of the interview accounts, will be considered in this chapter. Implications for the sociology of health and illness, and the practical connotations to be drawn for contemporary health policy are discussed in Chapter Nine.

The first stage in discussing the implications of the study is to consider how it has built upon and developed Baruch's work.

8.2 From 'moral tales' to 'assessments of health care experience'

Baruch's (1981; 1982)[133] analysis has provided a valuable starting point for this study. His approach to the analysis of interview data has provided me with a 'way in' to an ethnomethodological analysis of the interview data available to me for study. I did not set out to address specific issues in Baruch's study. However, my analysis has enabled me to constructively critique his analysis and offer a number of new insights on the status of qualitative interview accounts.

A re-reading of Baruch's analysis after the completion of this study has highlighted a number of limitations to his study. A particular tension arises in the way in which Baruch treats analyst's and members concerns. I will discuss the limitations I have identified in Baruch's study, before considering how my analysis offers a more detailed analysis of some of his stated concerns. Through this process, I aim to provide further support for the way I have proceeded, and explore what this means for methodological rigour and the status of qualitative research interviews (at different stages of interview research) in the sections that follow.

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[132] Otherwise the interviewees' concerns will be left only partially described and the analyst's concerns will be privileged.

I argue that, although members work to produce themselves as morally adequate in their interview accounts, a more detailed analysis of work by participants can yield greater insights for researchers, sociologists of health and illness, and policy makers and practitioners. The analysis here demonstrates that the display of moral adequacy is part of the work that interviewees undertake in collaboratively producing (with the interviewer) an 'assessment of health care experience'.

8.2.1 Baruch and moral tales revisited

As described in Chapter Two, Baruch set out to address a methodological failing he highlighted in earlier interview studies with parents of children with medical conditions by Voysey and Locker. However, Baruch argues that the analyses by Voysey and Locker are methodologically flawed in two ways. Firstly, Voysey and Locker (as analysts) do not show how parents display the status of moral adequacy through the construction of their accounts. Secondly, they do not demonstrate the normative character of the statements the parents make. Baruch sets out to address these deficiencies. It will be helpful here to reiterate his central aim:

> ...to show how parents display the status of moral adequacy by presenting determinate alternative possible accounts when considering unit troubles or problems. (1982: 39)

Baruch's analysis of interview data covers a number of issues relating to parents' contact with health professionals. Chapters were included on: parents' responses to their baby's disfigurement; parents' solutions to making congenital illness compatible with childhood; parents' interpretations of the causes of the illness (responsibility and blame); and the doctor-patient relationship. Through examination of these topics he produces his analysis of moral adequacy. He discusses implications for health care policy and practice at the end of each chapter.

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[133] I refer here primarily to Baruch's (1982) thesis.

The main areas in which limitations arise in Baruch's analysis, and the ways in which my analysis differs, have been outlined in Figure 8.1 on page 220. The points will not be addressed in strict order as there is overlap but they will be identified when discussed.

8.2.2 Members' versus analyst's categories (Figure 8.1, points 2 and 3)

Baruch states that his interest is in demonstrating the way in which accounts are constructed. He argues that statements made by researchers (e.g. Voysey) need to be supported in detailed empirical analysis. Otherwise the researcher can be accused of selecting data to support their theoretical propositions. Baruch attempts to address this problem by treating the interview data as situated accounts:

> In the present study, the research interview is considered as a situation in its own right with its own form of social organisation (1982: 12).

In this sense his approach could be said to be ethnomethodological. He uses two methods. The first is to identify the distribution of 'categories' in the data quantitatively and consider these as 'norms'. He then undertakes qualitative evaluation of a number of areas that arise in the data regarding his central aim.

A particular limitation of Baruch's work is that, despite the stated influence of ethnomethodologists such as Sacks and Cuff, his treatment of the interview data as a practical accomplishment by participants and consequently a situated account, is fairly loose. A tension arises between analyst's and members' concerns, which is not made explicit in the analysis (see Figure 8.1, point 3). Baruch primarily attends to his concerns as an analyst in order to address his goal of demonstrating how parents display themselves as morally adequate. This means that he is open to the potential charge he makes in his critique of Voysey and Locker, that data may be selected to fit theoretical propositions. Greater attention is paid to *what* and *why* questions, rather than examining *how* participants produce the talk. This has implications for how the analysis is to be understood, both by other researchers, and policy makers.

BARUCH	KELLY
1. Central aim of study, 'to show how parents display the status of moral adequacy by presenting determinate alternative possible accounts when considering unit troubles or problems' (p39). (Research problem derived from work of Voysey and Locker.)	1. Central aim of study, 'to produce an ethnomethodological analysis of qualitative interviews with bereaved spouses about the death of their partner'. (Adopted approach of ethnomethodological indifference to data analysis).
2. Interviewees' responses treated as 'situated accounts' (stated theoretical position), but does not demonstrate how members treat accounts as situated.	2. Situated accounts – set up as the interview.
3. Attends to analyst's concerns rather than members' e.g. parents responses to health professionals. Does not explicate how he has produced his analysis (based on members' concerns in the first instance).	3. Attends to members' concerns in the accounts, e.g. criticism of health professionals, assessment of experience. The work they do in producing the accounts, e.g. setting up entitlements to experience, opinion etc.
4. 'Crude' application of MCDA – demonstrates 'normative character of the accounts'. Does not show how categories and norms are generated (see Sacks, 1992; Silverman, 1998a).	4. Initial search for categories, then qualitative examination of membership categorisation and sequential work by interviewees.
5. Identities in the talk are taken for granted, e.g. 'parents'.	5. The production of identities in the talk is demonstrated.
6. Focus on 'atrocity stories' and 'moral tales'.	6. Assessment of health care experience.
7. Relationship between lay people and health professionals examined through interviewees setting up separate 'realities' (parental and medical).	7. Analysis of how interviewees set up lay and professional identities using Collections R and K (Sacks, 1992). Enables examination of how interviewees set up roles and responsibilities.
8. Limited attention to collaborative construction of accounts as interviews.	8. Attention to the collaborative production of the talk as the interview.
9. Does not explore use of categorical and sequential resources **by participants** in the talk. After the initial identification of 'categories' and 'norms', does not consider such resources, apart from 'intersubjectivity'.	9. Examines how participants set up accounts using a number of devices and resources, e.g. categorisation, sequence, assessments, course-of-action, economy.
10. Production of interview accounts as 'moral tales'.	10. Production of interviews as 'assessments of health care experience'.

FIGURE 8.1 – Key differences between the analysis of interview data by Baruch and Kelly

8.2.3 Categories in the talk (Figure 8.1, points 3, 4 and 5)

Baruch states that his quantitative application of MCDA, following Sacks, is crude. However, he does go on to make considerable claims for this analysis. His concern in using MCDA is to 'demonstrate the normative character of accounts' (p42). He distinguishes between 'membership categories', and 'types of norm', and identifies relationships between them. He shows what he has done by listing some categories and norms. He also considers the distribution of the categories invoked by the parents in their accounts. For example:

> The most frequently heard norm was concerned with the way a parent emotionally reacts to her child's illness. If we also include parents' affective reactions to professionals, then these norms were over three times more frequent than the next most frequent norm' (p50).

Let us consider this application of MCDA in relation to two examples which can be seen below.

Example 1 (Baruch, 1982: 51)

Parents description	Norm
He's been lately for about a fort- night, 'e really wasn't well, that's the worst he's been, 'e was really ill and I was worried.	A parent has a right to worry about her ill child.

Example 2 (Baruch, 1982: 53)

Parents description	Norm
He was very breathless and I kept saying to midwives and doctors and various bods that came round, um I said to the midwife look, I said he's breathing fast.	A parent is expected to inform a professional when her child is breathing fast.

Baruch shows us what he has done, but does not describe how the descriptions and norms are produced by participants in the talk analysed i.e. how categories are invoked (see Figure 8.1, points 3, 4 and 5). In the first example, the norm is expressed as a

statement about the parent's 'right' to worry. In the second example it is expressed as an 'expectation' to inform a professional. The way in which the parents produce these 'rights' and 'expectations' is not explicated. Given that the analysis is not made available to us, we must consider that the norms referred to are a researchers' interpretation of the parents' statements. This makes it difficult to assess the validity of this analysis.

This quantitative categorisation analysis is subject to Schegloff's criticism of MCDA, that it can be 'promiscuous' (Schegloff, 1992b; LC1: xlii)[134]. As a 'crude' application with no qualitative analysis of how categorisation work is done by participants in the talk, it is hard to assess the validity of the analysis (in relation to members' concerns). Adopting an ethnomethodological approach, means that the demonstration of how participants set up and use categorical and/or sequential resources in the talk under study to do social activities is the basis of analysis. MCDA is about demonstrating how members' concerns are practically accomplished in the talk:

> What one ought to seek to build is an apparatus which will provide for how it is that any activities, which members do in such a way as to be recognizable as such to members, are done, and done recognizably. (Sacks, 1974: 218).

If this is not demonstrated, as Baruch points out in relation to Voysey's and Locker's analysis, then it is difficult for the reader to judge the validity of the analysis. Although we could replicate the quantitative analysis (as Baruch claims), as it is not based on how members' produce and use the categories and norms in the talk, it is hard to assess its validity. As with other forms of quantitative research, we get reliability at the cost of validity (Hammersley, 1992)[135]. The lack of explication of members' work in producing the categories and norms means that in ethnomethodological terms, this would still not produce a valid analysis i.e. we cannot be sure that the analysis is accurately describing

[134] Schegloff argues that MCDA risks the analyst bringing their own categories and interpretations into the analysis.
[135] This is not meant as an indictment of quantitative research, and is not put in this way by Hammersley. It depends on what you are aiming for in your analysis.

what is happening in the data. Concerns about validity highlight the importance (at least in adopting an ethnomethodological approach) of doing the qualitative analysis first.

The use of categories and norms in this way is relatively static and hides the process through which members (and here also the analyst) produces them. Baruch states that he is following up this initial quantitative analysis in subsequent qualitative work, but does not directly link this form of categorisation analysis with his subsequent qualitative analysis, for example through describing in detail the work interviewees do in setting up and using rights and expectations.

If analyst's categories are used to describe and explain (without explicating how this is done by members), it is hard to see how the accounts are produced as situated (as external categories are being imposed on the data). Baruch might not be treating data as 'representations of external events' (p104), but he is introducing external (researcher's) categories to do the analysis, which he does not describe in detail. He refers to the way in which parents 'appeal' to features of things e.g. the medical process (p115), and 'display' things like 'involvement in the medical process' (p115), but does not demonstrate how the 'appeals', and 'displays' are produced (see Figure 8.1, points 3, 4 and 5).

Let us look at how Baruch analyses the following data extract, and consider what greater attention to the construction of the account in relation to members' concerns would add[136].

[136] The transcription style is Baruch's, including the numbers 1-5 relating to turns at talk. Line numbers have been added.

Extract 8.1 (Baruch: Extract 70, Interview 97, p160-161)

1	Mr St. (1)	And we got an appointment within a few days.
2		Um but everybody in the waiting room – people
3		With the same problems as us – you were in the
4		Waiting room at the hospital and this was
5		remarkable. Some people had been there for
6		6 or 7 hours and no one had a word of complaint
7		for the length of delay. Everybody there had
8		children and they all understood that Professor
9		EAS was giving ten minutes if it was necessary
10		for that child and 2 hours if it was necessary
11		to that child.
12	IR (2)	Yes
13	Mr St (3)	I mean you just had to look, wait, but you
14		knew you were in excellent hands and no one
15		complained all that time sitting there in
16		that horrible little room with no windows or
17		anything, kids running around everywhere.
18		No one murmured. It was amazing. Even guys
19		that don't look as though they've got much
20		intelligence with their kids, they're like
21		quite willing to wait and I thought that
22		doesn't happen very often you know.
23	IR (4)	Well are you saying that's a kind of mark of
24		respect or....?
25	Mr St (5)	Yes, yes. I thought the whole system was a
26		mark of respect for the hospital. Definitely.
27		And Profess- Dr EAS and his team. Very im-
28		pressed. 'Cause I only went there the once,
29		you see. To sit in the waiting room.

Baruch provides an analysis of this data extract:

> I have documented this lengthy extract in full since it so clearly displays the way parents were able to gloss situations which in the everyday world they would consider outrageous. Indeed, this was the essence of Mr St's accounts. By contrasting the patience of parents, even the most unintelligent ones, with the lengthy time they had to wait and the appalling conditions in which

> they waited, he portrayed the excellence of the specialist. This excellence was also reflected in the way he initially elevated the consultant's status from doctor to professor (see utterances 1 & 5). (1982: 160-161).

Baruch's comments about the way in which Mr St portrays the excellence of the specialist by contrasting the patience of the parents with their long waits are supported by the data. However, it can be seen that Baruch's analysis here is both limited and somewhat presumptive of the speakers' meanings. He pays little attention to how those meanings are (locally) constructed both by Mr St, and collaboratively with the interviewer. The importance of attending to members' categorisations in the talk if analysis is to be valid is demonstrated in Baruch's use of analyst's categories to interpret the data here. For example, he describes the parents as comparing the situation described with the 'everyday' world, when another possible meaning is that they could mean that it is 'remarkable' in relation to their usual experience of health care. It is also an assumption to make the interpretation that IE would consider this type of situation to be 'outrageous' in the 'everyday' world. We cannot know this from this data extract.

More detailed attention to how the participants are producing the talk reveals much more about the way they are constructing meanings here. A brief analysis of the data attending more to the local construction of the talk highlights a number of things that will be helpful to demonstrating how moral work is carried out in the talk.

Mr St sets up a context in lines 1 and 2 of a hospital waiting room occupied by people 'with the same problem'. He sets up a category set of people with the same problems waiting to be seen. The situation of being in a hospital waiting room with other people with the same problem is something which is 'remarkable'. This works as a story preface, which will be followed by an explanation as to why this is remarkable. On line 5 he mentions that some people were there for '6 or 7 hours' and ties it to no-one complaining about delays. He indicates that waits (for hospital appointments) are something which could be reasonably complained about by those waiting. This contributes to setting up a category set which includes lay and professional members (Collection K). The lay members are all those other parents (with children, though the

children themselves are not included in the category set) in the waiting room. In saying that 'no one had a word of complaint' he sets up a right for the lay members to complain. The professional member of this category set is 'the Professor'. The lay members 'all' 'understood' the professional's assessment of time required for a particular child/patient. Here 'understood', together with the lack of complaint about waiting indicates that the Professor's judgement was respected by all those waiting.

IE goes on to expand his story on line 13. He sets up the 'Professor' as someone whose expertise is recognised by each member of the (adult) lay group waiting. Again saying 'you just had to look, wait' indicates that it is the responsibility of a parent of a sick child to wait (to see an expert). No-one is forcing the parents to wait, but this is the only choice available in this situation. The reason for not complaining about the wait was that it was worth it as the professor was 'excellent'. The remarkableness of people not complaining (though they would have a right to do so), is further emphasised by a comment about the conditions associated with the wait, 'horrible little room with no windows or anything, kids running around everywhere' (lines 16-17). IE then goes on to make a distinction between types of (male) parent, those who 'don't look as though they've got much intelligence with their kids' (lines 18-20), and other parents. He prefaces his utterance 'that doesn't happen very often you know' with 'I thought', presenting it as his view, rather than a fact. Through this work, IE indicates that at least some lay people would usually complain about such waits, especially given the conditions. Saying 'I thought' also sets this up as an assessment during the event. He is demonstrating his observation of events at the time, and emphasising his role as a reporter of health care experience.

On line 23 the interviewer comes in with a query related to Mr St's assessment of his experience of waiting to see the consultant. He suggests an interpretation of what Mr St has just said, 'are you saying that's a kind of mark of respect or...?'. However, he sets this up as Mr St's possible meaning, rather than his interpretation as interviewer ('are you saying'). IR's object in his query, 'that' can be heard as tied to Mr St's 'that' on line 21, which refers to people waiting and not complaining (see analysis of lines 1-23

above). It is an interpretation which implies a moral, or point to Mr St's account. Mr St does not say anything about respect in his initial account, but then picks up on this in lines 25-29. He agrees with IR's suggested meaning to the account provided in lines 1-23 and and expands it. In this way it can be seen how moral meaning is jointly accomplished here by IR and IE. Not complaining in this situation is constituted collaboratively as a mark of respect for the hospital and the consultant and his team.

What does this analysis add to that of Baruch? I would argue that it tells us much more about how lay and professional relationships are set up, and how lay people set up rights to complain about the provision of health care. In initially prefacing his story as a description of something 'remarkable', Mr St. sets up this particular situation as unusual. It is unusual because people have not complained. In this way Mr St sets out a number of reasons for making a complaint about health care provision (in normal circumstances): long waiting times; different time allocations for patients; horrible waiting room; children running around; parents with limited patience with children ('guys that don't look as though they've got much intelligence with their kids'). It also tells us how lay people distinguish between types of lay people 'in the waiting room', those who are more or less patient and consequently more or less likely to complain. This indicates that lay perspectives on complaining take into account both the circumstances that may warrant complaint, and the 'type' of person that is more likely to complain[137]. Additionally we can see how 'respect' for certain professionals is recognised by lay people, in people not complaining (despite conditions which warrant it).

8.2.4 Atrocity stories and moral tales (Figure 8.1, point 6)

A significant part of Baruch's analysis is the construction and use of 'atrocity stories' by parents. As part of his study, he sets out to demonstrate how 'moral displays are accomplished through the atrocity story' (p68). Thirty per cent of the interview accounts were identified as atrocity stories. However, we are not shown how he or the

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[137] This is an example of categorisation by a lay person of other lay people in similar health situations to them but who are not members of Collection R.

parents come to categorise the accounts in this way. The notion of the atrocity story was drawn from earlier research by Webb and Stimson (1976). It is used in Baruch's analysis as a researcher's category. It is sometimes hard to see how the accounts are constructed as 'atrocities'[138]. Criticism of health professionals appears to be central to such stories. As seen in Chapters Three and Five of this thesis, criticism takes a number of forms and is embedded in members' practices in producing their accounts. This raises questions as to when 'criticism' becomes 'atrocity', and how events are constructed as atrocities by participants. My analysis indicates that interviewees exhibit greater sophistication in the way they construct their descriptions than use of the notion of the atrocity story implies.

Identification of accounts as atrocity stories draws attention away from members' concerns in the talk, to how different 'types' of story are produced and used. This is also the case to some extent with the focus on moral adequacy. The impression is given at

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[138] Atrocity is a rather extreme term. There do appear to be stories which are set up in this way. Interview 1 in my data could be seen as this type of story (for example, see Extract 5.1, Chapter Five). However, there does at times to be an over-statement in Baruch's study of what the interviewee is doing in the account, certainly in terms of criticising the behaviour of health professionals. This can be seen in the extract below where Baruch presents and analyses an 'atrocity story', which he describes as a 'dramatic account'.

Baruch (1982: 101 Mrs Hen, Extract 25, Story 9, Interview 31)

Mrs Hen They started at 6 o'clock in the morning. I went right round till late at night and nothing hap... I mean I was in labour but nothing was happening much. They kept bringing new born babies in... You know and all I wanted to do was to go to sleep and in the end they knocked me out. I slept through the night and I woke up having contractions and no pain, so they gave me more pills and I carried on the way through until a quarter to eight that night, Sunday night. So it was a whole weekend and she was born with a struggle at a quarter to eight that Sunday night. She was whipped straight away and I didn't see her.

Although the speaker may be presenting events in her account as a whole as an atrocity, it is not clear in the extract provided that what she is describing is an atrocity. The role of the health professional(s) is not clearly distinguished from the distress associated with having a child with a medical problem. Is the distress caused by the condition part of or separate from the atrocity of the health care experience. The atrocity story is a potentially useful notion, but its imposition as a category provides a limited interpretation of what interviewees are doing in their accounts. I would suggest that the notion of the atrocity story in talk about health care needs more detailed attention.

times, that providing a display of moral adequacy is given a special status by interviewees in their accounts, that this is the main thing they are doing in the talk[139]. For example:

> We shall see that such accounts (respondents criticisms of the medical profession) tell us about the moral character of respondents and not the way they are in fact treated by health professionals. (p11)[140].

The accounts may not tell us about the way respondents are 'treated by health professionals' (though we cannot know this for sure), but they do more than provide an account of the moral character of respondents. A focus on atrocity stories and moral tales can potentially pre-empt members' activities at different stages in the interviews. For example, in my data, the interviewees at times set up entitlements to produce assessments, produce criticism and praise of health professionals, and work to set up the interview as a particular form of interaction. However, it has been demonstrated in my analysis, that the work of participants in interview accounts of experiences of health care is about more than producing a display of moral adequacy. Such displays are an important part of producing descriptions of health care experience, but are used as a resource in the talk, rather than being the ultimate goal[141].

8.2.5 The interview as a situated account

Baruch raises two questions regarding interview data, which we can consider in relation to claims made for his analysis:

a) What status is interview data accorded?

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[139] As Gubrium and Holstein (1997) comment, 'we must describe members' interpretive circumstances and cultures, but not reify those cultures and circumstances in the process.' (p120).

[140] Interestingly although Baruch makes this point, he also argues that what the people say in the accounts about their experiences, should be taken seriously in relation to policy issues and formulates implications based on what they say. This presents a mixed message regarding the status of interview data analysis.

[141] It should be noted that whereas we have both carried out analysis of interviews with 'carers', the form and content of the talk may be influenced by the difference between parents talking about an ongoing health scenario for a child, and bereaved spouses talking about the death of a spouse six months later. The presentation of moral adequacy may therefore be more explicit (on the part of the interviewees) in Baruch's data.

b) Can the interpretations made of this data be demonstrated in such a way that they are not open to the criticisms of being selective and simply suited to the chosen orientation? (p62).

Taking question (b) first, we have seen that problems arise in relation to Baruch's treatment of the data, and claims made for the analysis. This has implications for question (a).

Baruch states that the displays of moral adequacy by parents in their accounts are constructed for the research interview[142]. However, he does not examine in any detail how the talk is collaboratively constructed as the interview, and how this influences the analysis produced. Although he states that he attends to the work of the interviewer in the production of the accounts, this is in fact minimal.

Lack of attention to the construction of the accounts as an interview means that question a) above cannot be satisfactorily addressed by the analysis. It also raises an important point regarding the status of moral tales in relation to the research interview. Baruch comments, 'In the present study, the research interview is considered as a situation in its own right with its own form of social organisation' (p12). However, as this social organisation is not demonstrated, we are left unclear as to *what status* participants in the talk attribute to the moral tales. In order to consider the status of the moral tales relative to research interviews, we need to see how participants are producing them as research interviews. Otherwise we do not know if they are situated *in* the interview, or could be presented in the same way in other settings e.g. everyday talk.

Baruch refers to the interviewees primarily as 'parents', yet this identity (and others), is taken for granted in the analysis. It is not shown how the parents constitute themselves as such in this data. This is significant, because using the category parent in this way means that attention is drawn away from how the identity parent is situated in the

[142] Baruch (1982) states in the abstract to his thesis, '...these responses are treated as situated accounts constructed for the research interview which display the respondent as a morally adequate parent' (1982: 1).

interview. The question then arises as to how the accounts are treated as 'situated' for the purposes of analysis.

This can be compared with the value identified in the present study, of demonstrating how identities are produced both in and through the talk. In particular, the construction of the identities interviewer and interviewee have an important bearing the nature of the account produced. As Baker (2002) comments, 'the interview data *are* the social organization of talk between interviewer and interviewee' (p793). Analysis of interviews in this way demonstrate the 'artful practices of interviewer and interviewee in making the interview happen, and consequently it becomes very difficult to unhitch "answers" from their (em)bedding in an actual, local situation of production.' (p793). It tells us what status participants attribute to the talk. The attention given here to the construction of the talk as the interview adds considerable depth to the analysis, and demonstrates how participants are producing the accounts as assessments of health care experience.

This critique of Baruch's analysis, made possible in part by insights developed from the current study, raises some issues for researchers about how interview data should be considered, not just at the level of analysis, but when the study is being set up and designed, and when policy is being discussed. These issues will be discussed in the next section.

8.3 The role of theory

The status of interview accounts is tied to theoretical concerns. This is reflected in an early comment by Cicourel on interview research:

> The attempt to make the interview a more valid and reliable instrument cannot be performed without consideration of basic theory because such theory is a built-in feature of every interview and therefore presupposed in its very conduct (Cicourel, 1964: 74)

The importance of theory to qualitative method was described in Chapter One. Data are collected in order to consider theoretical questions, and methods of data collection

'instantiate theories of their own which serve both as legitimators of the method and as justifications for the method doing the job it is intended for' (Ackroyd and Hughes: 183). Methods should therefore not be treated as 'atheoretical tools' (p183). The theoretical approach to the data will influence claims that can be made for it. Description and theory in qualitative research are closely intertwined. As Hammersley comments '...descriptions cannot be theories, but all descriptions are theoretical in the sense that they rely on concepts and theories.' (Hammersley, 1992: 13). Let us consider the application of ethnomethodological principles to the interview data.

8.3.1 Attending to categorical and sequential concerns in the interview data

Intellectual divisions have arisen within ethnomethodology regarding the relative status of MCDA and CA in producing valid analysis (see Schegloff, 1992b; Hester and Francis, 2000; Watson, 2000; Watson, 1997). Ethnomethodological researchers tend to favour one or other method. Explicit attention to both categorical and sequential resources in analysis is relatively unusual[143]. Contemporary CA researchers generally argue that analysis of situated action 'should begin from the study of sequences of actions and ways in which context forms a resource in their interpretation' (Drew and Heritage, 1992: 13). This is considered to produce valid analysis of members' concerns as the collaboratively produced nature of phenomena is observable in sequential structures. Analysis of members' categorisation work is considered by some CA researchers to be open to 'incipient promiscuity' on the part of the analyst (Schegloff, 1992b; LC1: xlii). MCDA researchers counter such criticism with arguments that CA researchers take category relations in talk for granted and therefore downplay this aspect of members' work in analysis (Hester and Francis, 2000). The position taken here is that of Watson (1997), who argues that categorical and sequential phenomena in talk are 'two sides of the same coin', and in many respects are aspects of each other (p73). Both MCDA and CA have been applied in order to produce a detailed case study of qualitative interview data.

[143] See Schegloff, 1972; Silverman, 1997; Rapley, 2001 for examples of studies which have applied both MCDA and CA.

Debates within ethnomethodology about the validity of MCDA and CA raise the issue of how the topic of study (Garfinkel and Sacks, 1970) is to be conceived. Schegloff's (1992) critique of MCDA infers that the analyst is in danger of treating the data as a resource, rather than the topic of analysis. This has implications for the way the notion of context is regarded by researchers. Heritage (1984) argues that the CA approach to context treats it as something which comes about through members' practices. As noted earlier (Chapter One, page 33), members actions are shown to be at times context shaping and context renewing (Heritage, 1984), rather than being set up through externally imposed social structures. Analysis of the interview talk in terms of its sequential structure has demonstrated how the talk is collaboratively produced as an interview by participants. The way in which the interview context is set up by participants in the talk is demonstrated. However, membership categorisation analysis of interviewees' accounts has demonstrated how they set up and use context as a resource in their descriptions of experiences. The analytic problems are different but both methods are ethnomethodological, and as such are based on the principles of such study set out by Garfinkel and Sacks' (1970). The interview participants do both sequential and categorisation work to achieve different but related actions. There is therefore significant value in doing both types of analysis where it is appropriate.

When the categorisation and sequential analyses of the interview data are considered together a case can be made that interview accounts are constructed by the participants as assessments of health care experience. The participants (especially the interviewee) direct the recipient(s) to a particular hearing of the events described. In this way the interview accounts are attributed a particular status by the participants. The status of interview data for participants has important implications for how the data are to be interpreted and applications developed and will be discussed in more detail in Chapter Nine. This approach differs from that of Baruch. He counters scepticism from those who query how it is possible to move from treating interview data as situated accounts to commenting on external activities:

> ...whether parents' accounts actually describe their conduct on the occasions they are discussing is unimportant. What matters is that parents are able sensibly to apply them in the context of discussing issues to do with the family's situation, therefore we should treat them seriously. (1982: 16-17).

Baruch does not adequately explain how this is to be done[144]. I agree that the accounts should be treated seriously but argue that this means that the accounts should be treated as participants set them up to be heard. Otherwise there is a danger of (unreliably) treating the issues described as a 'reality report' (Holstein and Gubrium, 1995) and making policy recommendations on that basis.

In my analysis I have attempted to follow Sacks's call to produce an adequate sociological description of members' concerns in the interview data. The way the talk is treated as the topic of analysis is considered in two different ways. It was seen in Chapters Six and Seven how the interview talk is set up collaboratively through sequential work on the part of the participants. The sequential analysis has involved treating the data as a primary source, in that the topic of interest is the collaborative production of the interview talk. The interview context is seen to be set up and oriented to in the interview openings[145]. The categorisation analysis described in Chapters Three, Four and Five treats the actual descriptions, or what is talked about, as the topic of analytic interest. In this sense the categorisation analysis has involved treating the data as a secondary resource. However, members are seen to use recipient-design as a resource when they do categorisation. This was seen in the way intersubjectivity and ambiguity were used in order to collaboratively produce criticisms of health professionals in Chapter Three (for example see Extract 3.3, page 72). In line with the ethnomethodological idiom discussed in Chapter One, both MCDA and CA involve identifying members' use of resources in the talk, but look differently at how those resources are used and what work they are used to do. The way in which this data has been treated as the topic of analysis and how this affects implications to be drawn is discussed in Section 8.5 below, and in Chapter Nine.

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[144] This approach to policy implications also sidetracks the implications of the analysis.
[145] It is also oriented to at other points in the interviews but this has not been formally analysed.

Decisions about method are made on the basis of the analytic interests of the researcher and practical concerns. In particular the type of data available and other pragmatic factors will influence the possible methods that can be applied (Silverman, 1987). MCDA and CA are appropriate methods for analysing talk. Adopting either of these methods will influence the nature of the research problem to be examined. One of my reasons for choosing MCDA in the first instance was its applicability to accounts where one person does most of the talking. CA is more appropriate to the analysis of talk where two are more people are co-present[146] and therefore there were limited opportunities for applying it to my data.

All social practices are appropriate sites for sociological study. However, we do not have access to all social practices with the methods we have available[147]. Valid and reliable ways of examining the range of forms which social phenomena take need to be developed. All forms of data have their problems (Hammersley and Atkinson, 1983), and no method will ever be perfect. As Gubrium and Holstein (1997) comment, 'we must describe members' interpretive circumstances and cultures, but not reify those cultures and circumstances in the process' (p120). This includes ensuring that certain types of data are not privileged[148].

8.3.2 The limitations of ethnomethodology

A potential problem with ethnomethodological inquiry is that if taken to its logical end, the possibility of knowledge of the social world is denied given that researchers'

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[146] This can include non-verbal actions in video data (for example, see Heath, 1997). However, the data need to involve two or more people in order to examine the talk as a collaborative production using CA. It could also include data where two or more people are speaking, such as telephone calls.

[147] Sacks's (1992) interest in using conversation data was partly based on its easy availability. He did not argue that it should be a privileged form of data.

[148] It has been discussed in Chapters Three (page 95 and Five (page 153), that in a recent special edition of *Text* on 'lay diagnosis' (in medicine), all but one paper are analyses of clinical interactions. Drew (2001) notes that the one exception, a study of telephone conversations between a patient with terminal cancer and members of her family, 'adds another important dimension to the holistic picture which is beginning to emerge of the connections between patients' experiences in their ordinary lives, and their accounts and explanations, and 'lay diagnoses' in clinical settings' (p265-266). My point here is that different types of data and analysis complement each other, and contribute to building a more informed understanding of social phenomena.

analyses themselves can be shown to be 'a product of interpretive and interactional work' (Hammersley and Atkinson, 1983: 138). It has also been suggested that a danger in explicating the apparatus that people use to do things means that the analysis becomes devoid of meaning:

> Ethnomethodology risks reality's melting into representation as it focuses on the *hows* of reality construction at the expense of the *whats* of lived experience..... Members' representational practices displace the separate realities they represent.... This serves to obscure the distinct, meaningful consequences that specific applications of methods have for members' lives. (Gubrium and Holstein, 1997: 107)

This problem is also identified by Sacks (1963) in his discussion of the need to distinguish between commonsense and analyst's concerns in the data. My aim has been to make explicit the work that members are doing in the data, bracketing phenomena so that they can be studied. As Schegloff (1997) comments, 'You need to have technical analysis *first*, in order to constitute the very object to which critical or sociopolitical analysis might sensibly and fruitfully be applied.' (p174). In attending here to how the accounts are produced first, my analysis has demonstrated the way the interviewees set up what is to be heard and understood. This makes it possible to discuss the content of their descriptions e.g. the relationship between lay and professional identities, in terms of how they are produced. Shifting between *what* and *how* questions, 'keeps the analysis of interpretive practice self-consciously attentive to both the world researched and the researcher' (Gubrium and Holstein, 1997: 212).

My analysis has described how the interviewees undertake a range of activities in the descriptions they produce. Identifying how the talk is locally situated establishes the status of the accounts. Once this has been done we can begin to describe what activities and events participants, in particular the interviewee, make relevant in their accounts. As discussed in Chapter Five, participants in talk orient to the larger projects in which they are engaged. If these larger projects are referred to by participants, then we can and should describe and discuss them. Establishing the status of the data makes it possible

to examine how the interviewees describe certain topics, such as health care experience. The analysis here has demonstrated the value of looking at *how* events are described. For example, we can see that there are restrictions on talking about certain experiences, meaning that entitlements need to be set up.

Baruch's concern that Voysey and Locker laid themselves open to the charge that they had been selective in developing their analysis is probably true of all research. Methodological choices have been made at different stages in this study. However, these choices have been influenced by the need to attend to members' concerns in the data[149]. For example, a key concern in the data for interviewees has been the relationship between lay and professional roles and responsibilities. MCDA was an effective way of analysing these concerns. CA was applied to the data in order to explicate the way in which the identities interviewer and interviewee were set up and used. This may go some way to addressing a concern raised by Andrle regarding qualitative inquiry:

> Calls for methods that occupy a middle ground between realism (or 'naturalism') and constructivism (see Gubrium, 1993; Gubrium and Holstein, 1997) may be difficult to heed successfully at all times, because an analytic choice has to be made to give a particular enquiry a clear primary focus. It is however, possible to rescue realist enquiries from naivety and constructivist enquiries from sterility by showing some narrative context in the former and some witness contents in the latter. It is equally feasible to apply different analytic choices in successive enquiries into the same data set. (Andrle, 2001: 818)

The value of having different theoretical approaches and critiques contributes to the production of better analyses through methodological tensions (Gubrium and Holstein, 1997). In applying two methods to the same data set I have been able to identify three different ways in which interview participants set up and orient to context:

- How the interviewee and interviewer do assessment/evaluation of health care experience;

[149] I cannot of course say that this analysis is comprehensive in the sense of attending to all the concerns of participants. I have made explicit choices as to what research problems to pursue at different stages. These selections are based in part on my interests as a sociological researcher.

- How interviewees describe their experience of death of a spouse;
- How the interviewee and interviewer produce the interview as a situated account (for a particular purpose).

The different analyses of members' concerns, demonstrates that the interview accounts are produced, not only as moral tales but as assessments of health care experience. Producing a moral tale in the way Baruch describes is an important resource in doing such evaluation. Applying CA to the interview openings has been analytically valuable in making it possible to see the status given to the interview data, not from the perspective of the researcher, but from the practical actions of the participants in the talk. Categorisation analysis identified how interviewees produced accounts, making distinctions between personal and societal experience, opinion and fact. Interviewees are seen to produce versions of events (cf Cuff, 1980), but they can only construct them together from things that they know, their stock of knowledge (Schutz, 1970).

8.4 The status of interview data

Gubrium and Holstein argue that:

> ...we should be able to locate options for reclaiming reality without discounting representation, for acknowledging that reality is not merely given, but constructed. (1997: 112)

The interview accounts are produced as assessments and it can be inferred that they are to be heard in this way by the audiences at which the talk is aimed. For example, we have seen in Chapters Four and Five how interviewees use opinion when making assessments of health professionals, rather than setting up their descriptions as direct reports. They also set up entitlements to present their opinions, in part in relation to their involvement in the description as a lay person, either in relation to other lay persons they have responsibilities to, or health professionals who have expert knowledge. The interview accounts are presented as individual accounts based on observations that the interviewees are entitled to make. They set themselves up as

reasonable and morally adequate. They also demonstrate the selectivity of their accounting practices through use of devices such as economy, course-of-action, and intersubjectivity.

There has been criticism of the apparent over-reliance on the interview as the method of choice in social research (Atkinson and Silverman, 1997; Silverman, 1998c). Such criticism is partly influenced by the preference of naturalists and conversation analysts for undertaking research in 'natural' settings. However, as Hammersley and Atkinson (1983) argue, the distinction between 'natural' and 'artificial' settings is misleading (p11). Ostensibly artificial settings, (such as research interviews) are also part of society and can therefore be analysed. In addition, '...all research, however, exploratory, involves selection and interpretation'. (Hammersley and Atkinson: p13)

Identification of the work that participants do in producing qualitative interview accounts enables researchers (and policy makers) to make more informed choices about method when planning studies. On the basis of this analysis it is suggested that research interview data of this type provides a rich sociological data source (in terms of the practices members use in constructing their accounts). However, as discussed above and in Chapter Two, the aim of the analysis, including theoretical concerns, should be made explicit.

8.5 Studying the interview as a social institution

Interviewing is, among other things, a social research method (Ackroyd and Hughes, 1992 - my emphasis). Ackroyd and Hughes comment that there has been extensive research on the effect of interviewer characteristics on the interview situation and the qualities of the respondents' replies but this has primarily been undertaken in survey research. Drawing on Cicourel (1964), they state:

> The rules of interviewing are practical procedures for managing a social encounter in order to get the interviewing done and achieve meaning equivalence in the material..... 'Resolving ambiguities', 'letting certain remarks pass', 'allow propriety to constrain lines of questionning',

> 'hold meanings in reserve', 'giving the benefit of the doubt', and more, all involve the interviewer's use of his or her common-sense knowledge of social structures to make sense of the replies, the coding task and, later, make sense of the tables produced. (p121)

It was discussed in Chapter One that, although there is a significant body of ethnomethodological research on interviews in a number of contexts including health in particular, there has been relatively little empirical analysis of the research interview as a social encounter until recently. The study of the research interview as a social institution in its own right can be considered in relation to Heritage and Greatbatch's discussion of the status of the news interview as an appropriate object of ethnomethodological study:

> ...the news interview conventions we have described and the proprieties they sustain bear all the hallmarks of a social institution as traditionally conceived within the discipline of sociology. They are culturally variable; they are somewhat subject to legal constraints; they are subject to processes of social change; they are the object of debate and discursive justification. The comparative and historical study of these practices has yet to be developed. The impact of technological change, of political processes and pressures, of economic competition between broadcasting organizations, and of institutional dynamics within them, has yet to receive an assessment. Similarly, the impact of these changing practices on the shifting political cultures of contemporary societies awaits investigation. It is here that the study of news interview talk as a social institution, will intersect with the study of social structure (Heritage and Greatbatch, 1991: 131).

These issues can and should be raised regarding research interviews. The notion of the 'interview society' (Atkinson and Silverman, 1997) is a powerful one in contemporary western cultures. It is the province of both researchers and those researched. This makes it not only an appropriate site of sociological study, but an important site of such study[150].

Conventional approaches to describing interviews tend to consider interviewer and interviewee actions or behaviours in the interaction e.g. the way in which certain types of question produce certain types of answers. The emphasis in text books is on maximising the skills of the interviewers. An important finding here is that the interviewees are themselves demonstrably skilled in producing interview accounts. They do not merely respond to the request set by the interviewer, they select a particular story to tell or negotiate the type of story required with the interviewer. The one exception to this supports the analysis (see Chapter Seven, Section 7.5). Interviewees also assess the experiences described while drawing the interviewer into the production of their assessments. Together they produce an assessment of the experience of health care during the terminal illness and death of a spouse (see Chapters Four and Five).

8.6 Is the interview an appropriate method for social research?

It has been argued that, 'No form of interview study, however devious or informal, can stand as an adequate substitute for observational data' (Strong, 1980: 7). Strong's comment comes in a paper describing an interview study of GPs' perspectives on treating alcoholic patients. He is very clear about the status of his accounts, moderating the claims he makes for analysis. Despite this proviso, the interview study he presents provides an insightful analysis of the way in which GPs deal with alcoholic patients. Taking up Strong's point, I agree that interview studies cannot be used as an adequate substitute for the study of actual practices. However, I would add another proviso, that it depends upon what you want to investigate.

This study has attended to how interviews are collaboratively produced by interviewer and interviewee. To move away from the local production of the talk for a moment, I suggest that this collaboration happens on a macro- as well as a micro-level. Interviews are selected as the method of choice by researchers *and* interviewees. One of the main

[150] There are also strong pragmatic reasons for studying qualitative research interviews as a social institution. One reason is the cost of such research to both public and private sector organisations. As

reasons researchers choose interviews as a method is because people will agree to be interviewed, in fact they could be said to 'choose' to be interviewed. Interviews are not just a researcher's method of eliciting information but are a way of people giving it. They tacitly know how to do 'being an interviewee'. This is implied in a number of ways in my data analysis, such as the relative ease with which the interviewees found the story the interviewer wanted to hear.

As discussed above and in the following chapter, interviews can produce useful information about the social world, depending on what you are interested in. A difficulty arises when the selection of the interview as a method is treated atheoretically, and is not attended to in the analysis. The crucial issue is the way the analysis is treated, either as a representation or a reality report (Holstein and Gubrium, 1995). The interview is not an appropriate way of gaining accurate information on actual events. The status of the data needs to be considered in research papers i.e. that they are accounts of experience, rather than the actual experiences themselves[151]. The importance of this will be discussed further in Chapter Nine. Another way of looking at interview data is to examine the way they are constructed as accounts, through the categorical and sequential work that participants do in producing these representations. This enables us to begin to uncover how commonsense reasoning about the events described is conducted. In this way, interview data become a rich data source of information on how the interview society works.

A further reason for studying interview accounts is that they are places in which phenomena like health and illness exist. Health and illness do not just exist in hospitals or at the patient's sick bed. As Gubrium (1988) demonstrates in relation to the family,

such institutions are present wherever people construct them. They are part of their social interaction. In my data interviewees describe the death of a spouse, producing an

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with all areas of public service, there is an increasing emphasis on accountability.

account that represents their experience of health care. They make it clear that they are providing a selective account of their experience. They contribute to setting up the status of the account. This was explicitly seen in Extract 5.1 (Chapter Five), where IE says 'that that is er (0.6) most of it you know (0.2) in a nutshell' at the end of his story. However, such representations contain a great deal of valuable sociological information about health, illness and health care.

Interview accounts are treated by interviewees as versions and are not presented as a 'true' reflection of events. This was seen in Chapter Three in the way the interviewees use caution and ambiguity in their descriptions, and draw the interviewer in to the construction of meaning e.g. to do criticism. This analysis indicates that the way in which the interview accounts are being treated by interview participants, and analyst needs to be made explicit in research papers. This makes it possible to see the status of the data and discuss the implications for sociology, policy and practice, which will be discussed in the next chapter.

[151] I am not suggesting that all interview studies need to be examined according to ethnomethodological principles. However, adequate attention needs to be drawn to their limitations. Although in theory this happens, policy implications are often drawn as if the data are representations of actual practice.

CHAPTER NINE

PRODUCING LAY ASSESSMENTS OF HEALTH CARE EXPERIENCE

9.1 Introduction

This chapter will discuss the implications of the data analysis for the sociology of health and illness, and health care policy. Attention to the practices of participants in constructing the interview accounts has revealed a number of activities in the talk which help to shed light on a current concern in the sociological study of health care, lay experience. The main focus is on how accounting practices such as the use of resources like lay and professional identities and entitlements to experience are used to set up the interview accounts as assessments of health care experience. The chapter draws implications from the analysis regarding a number of key issues in health: the status of the interview as a method of data collection and analysis; the construction of lay and professional identities (and knowledge); the relationship between lay assessments of health care and evaluation (including studying consumer satisfaction); and the role of informal carers.

9.2 Implications for the sociology of health and illness

Qualitative interviews are frequently used in sociological research (Atkinson and Silverman, 1997; Mason, 2002; Douglas, 1985). They are also the most commonly used method of qualitative data collection in health care settings (Britten, 2000)[152]. The use of qualitative interviews in health research is likely to increase even further with the emphasis in current health policy on eliciting consumer views[153]. It was seen in Chapter Eight that concerns have been raised by some researchers about the application of the interview as an atheoretical way of collecting data. This has led to calls for more theoretically-informed research in health and illness (Zoppi and Epstein, 2002; Popay et al., 1998). My study is underpinned theoretically in two ways, through the adoption of ethnomethodology as an analytic approach, and through a stated interest in developing understandings of the moral work participants do in producing accounts of the illness

[152] A critique of qualitative interview research published in the mid-1990s showed that 55% of qualitative data articles in the journal *Sociology* had employed interviews (Silverman, 1998c). This was even higher in *Qualitative Health Research,* with 71% of papers in this journal using interviews.

[153] For example, the majority of the 12 studies included in a recent research initiative funded by the Department of Health on 'patient partnership' included qualitative interviews (http://www.info.doh.gov.uk/doh/rd2policy.nsf). Several of the studies included multiple methods.

and death of a spouse. The value of my approach to the analysis of interview accounts in the study of health and illness will be considered.

It was argued in Chapter Eight that, if we want information about what actually happens when people receive care during a terminal illness, we need to observe what happens *in situ*. However, health and illness do not just exist in the hospital or at the sick bed, but come about through social action, including discursive practices[154]. As Atkinson comments:

> The narrative organization of health and illness, and of medical work, is unquestionable. The temporal trajectory of illness careers is organized through the narrative unfolding of events and evaluations; the illness trajectory is a situated production, enacted through the occasioned tellings of illness experience. (1997: 340)

Health and illness can exist in a wide range of social settings, i.e. wherever members make them relevant. The research interview is becoming an increasingly important site where health and illness are invoked, given that the perspectives elicited in such interviews may be used in the evaluation and development of health services (this will be discussed further in Section 9.3 below).

9.2.1 Studying interview accounts

Following Baruch I set out to collect and analyse accounts of the experience of the death of a spouse from cancer. I refer to these as accounts or stories, though they could also be referred to as 'narratives'. Narrative analysis is becoming increasingly popular in the sociology of health and illness (Bury, 2001; Atkinson, 1997), and in medicine (Greenhalgh and Hurwitz, 1998)[155]. The emphasis is on understanding the experience of the patient or lay person (Greenhalgh and Hurwitz, 1998; Popay et al., 1998), although

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[154] This is also discussed by Gubrium (1988) in his study of 'the family as project'. He argues that: 'Because the family in the large enters into everyday experience as a discursive formation, its conduct cannot be revealed by means of methods exclusively focused on individual experience. ...we must search for the sum and substance of family conduct in the family project, in the discursive applications that both realize and respond to it' (p293).

[155] For example, the British Medical Association has held a number of 'Narrative based medicine' conferences in recent years. It is in part seen as a way of providing a counter to the emphasis on 'evidence based medicine' (Greenhalgh, 1998).

there is also interest in analysing professional accounts and the narrative nature of medical knowledge (Hunter, 1991; Loewe et al., 1998).

Narrative analysis is seen as a way of avoiding the fragmentation of interview data which can happen with the identification and analysis of themes (Reissman, 1993). Narrative accounts are usually collected through interviews and can cover someone's life story, or a particular aspect of their personal experience. Andrle (2001) comments that sociological interest in life story interviews involves the adoption of either a realist or constructivist position. Realists treat the data as representative on some level of social reality. Constructivists on the other hand regard the data in terms of their constitution as communicative actions. Andrle (2001) suggests that there are two different ways to approach life-story interview data from within the constructivist approach:

- by examining the interactional process that produced the narrative, the practical context of its telling;
- or by focusing on the internal coherence of the life story, its gestalt-defining thematic structure and emplotment, and narrative genre.

A great deal of narrative health research falls within the second constructivist approach described by Andrle above. For example, Williams (1984) distinguishes between two aspects of narrative in his study of chronic illness, the 'routine' and the 'reconstructed' (p178). Routine narrative is a process of continuous accounting whereby the incidents and events of daily life are given some plausible order. Narratives are 'reconstructed' when individuals are presented with disruptions, such as illness, which make it difficult to map the 'orderly sequence of facts' (p178). Williams argues that it is the latter that is of direct interest to health researchers. He argues that individuals use narrative knowledge in their interpretation of existing social norms and cultural values so that they can pursue a virtuous course of action in response to the consequences of their illness. Williams provides an insightful analysis of narrative data which focuses on the internal coherence of the story. However, it could be said to gloss the detailed processes used to

produce the story. This is where my interest in the sociological analysis of stories (or narratives) lies[156].

Let us consider how an ethnomethodological approach to qualitative interview accounts can contribute to the sociology of health and illness.

9.2.2 The production of interview accounts

Recent critiques have warned against treating narratives as a special form of account in the sociology of health and illness. For example, Bury (2001) comments:

> ...sociological and medical attention to narratives needs to distinguish between different levels of experience and the verbal accounting processes relating to them. This leads the analysis to a wider understanding of the contexts and the 'vocabularies of motives' in which narrative forms and thus self-identity are constructed and employed....chronic illness narratives are important for a better understanding of the social fabric, and the contradictions of social interaction and self-presentation, not simply a 'truer' picture of illness or the basis for improving medical practice, important though the latter may be. (p282-283)

Atkinson's (1997) concern is with the focus of narrative analysts on the personal and private experience of the individual, such that, 'Narrative is celebrated as the revelation of the personal and the interview as the research device for its authentic elicitation' (p334). This is viewed as a problem by Atkinson who further argues, 'We should not endorse those cultural conventions that seek to privilege the account as a special kind of representation' (p341). Both Bury and Atkinson endorse the study of narrative as a mode of representation in social life but argue that the methodological challenge it presents to sociology is often underplayed. Narrative analysis, as with other methods, needs to be conducted through systematic, principled investigation, rather than be treated as a solution to the multiple problems of social analysis (Atkinson, 1997: 325). Sacks's work on storytelling offers some valuable insights into the sociological study of narrative, which have been drawn upon in my analysis of interview data.

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[156] I use the terms 'story' or 'account' to refer to my data. However, my analysis can also be considered as a form of narrative analysis. I therefore use 'narrative' at times in this chapter, as a reflection of the literature referred to here.

9.2.3 Sacks on storytelling

Sacks's (1992) discussions of storytelling offer a different approach, which goes some way to addressing the methodological concerns raised by Bury and Atkinson. He describes how members use resources such as recipient design, categorisation, and sequence in producing accounts, emphasising the need for the researcher to attend to the often complex accounting work undertaken. Sacks's approach makes it possible to undertake analysis which does not externally authenticate or privilege the accounts of storytellers (i.e. those providing narratives) but demonstrates the accounting work through which their stories are to be understood or treated.

Sacks's (1992) discussions of storytelling are scattered throughout his published lectures, and do not fall formally under either MCDA or CA. Sacks focuses on a number of procedures that are drawn upon in telling a story, such as prefacing or telling jokes. However, analysis of these procedures taps into the actions of interview participants and can provide a valuable tool for describing accounting practices. Sacks's fundamental approach to storytelling is discussed by Schegloff (1992b) in the introduction to the second volume of lectures:

> Sacks parries the issues of "what is a story?" and "is this a story?" by asking not whether the label "applies"... but whether it is relevant – that is, relevant to the participants in producing the stretch of talk in and through which the object in question was produced. The issue is thus transformed from an "external analyst's" issue into a "a Member' s issue:" how does it matter to the teller and the recipients that the talk being produced *(in the course of producing it)* is "a candidate story"? (LC2: xxv)

Sacks (1992) shows how the analyst can go beyond the descriptions of a series of categories members are using to the way in which members use them to achieve particular actions that make up the 'social fabric' to which Bury refers:

> What we're asking is, is there some set of features that stories have so that one can have some principled basis for using what is after all a lay characterisation. What we want to find are some features that have been put into it which provide for its recognisability as 'a story'. We want,

> then some features that are not just there incidentally, carried-along artifacts of its being a story, but features that are put in, in the making of a story. (LC2: 18)[157]

Producing some talk in a form that is recognisable as a story, or recognising that a story is being told may on the surface of things seem quite straightforward activities. Recognising some description as a story means that the activities described are viewed as doing some action. The work of recognition occurs at a number of levels in my interview accounts. At the start of the interviews, as seen in Chapters Six and Seven, the interviewer requests a story. However, the nature of the story required is not always clear to the interviewees who at times query where they should begin and/or what the story should contain. The importance of recognising the form the story should take is emphasised through analysis of a deviant case where the interviewee begins her story in a different place and is guided to the required story by the interviewer.

Sacks' approach to stories is to consider the interactional work they do, including how they are relevant at this particular point in the talk. He argues that storytellers build in characterisations regarding what sort of news their story might be a candidate for. It was seen in Chapter Three (page 77) that recognition of the talk (in the extracts) as stories is fundamental to producing a criticism. This is also the case in the extract below.

Extract 9.1 (Interview 5 – repeated from Chapter Three (Extract 3.5))

1	IE	but (.) when it was confirmed as a stroke (0.2) well so called confirmed we said it
2		looks like a stroke to the doctor down there (.) and he said `it would seem so' they
3		were his words `it would seem so' (.) but really it was a bit of the lung cancer
4		(.) I mean I don't know the technical terms for it (.) but it was the lung
5		cancer reaching the brain as it was did Roy Castle (.) and course it wasn't
6		until after a few days that we realised what was happening (0.2) we didn't
7		understand it well we're not medical people are we? you know (0.8)

The interviewee makes a point about the inadequacy of a particular doctor through describing the events surrounding her husband's diagnosis. Through the categorization work she does, she sets up his accountability as a professional. Recognition that the

[157] This quotation from Sacks was also included on page 188.

speaker is telling a story in this extract means that it can also be heard as a criticism. As Sacks (1992) comments:

> The sheer telling of a story is something in which one makes a claim for its tellability. To work it up into a piece of possible local news is to make it tellable. So that it isn't just another description, put in there for the hell of it. (LC2: 10)

If the story was not recognised the relationship between the events in the extract, which establishes the interviewee's meaning (the criticism), would be missed. The moral implication of the description is closely tied to recipient-design considerations. For example, interviewees are seen to use ambiguity at times as a resource to construct their criticisms. The criticism in Extract 9.1 is difficult to resist by the hearer because of the way it is set up.

Sacks's work on storytelling has been applied in a number of forms throughout the analysis of the interview data. It has helped me to identify a number of procedures that interview participants use in describing the death of a spouse. Analysis of the interview openings has demonstrated the importance of story recognition in producing an open-ended question and response (see Chapter Seven). Story recognition is also an important feature of doing criticism in these accounts (see Chapter Three). Sacks's discussions of how storytellers set up entitlements to describe particular experiences has been pivotal in the examination of assessment work in the interview accounts. This has been used to develop the analysis in conjunction with MCDA, so that the way lay people set up accountabilities for their actions in the talk, and those of the professionals, can be observed in detail.

To return to the points raised by Bury and Atkinson above, attention to how accounts are constructed by those engaged in producing them leads to greater insights into areas like the establishment of identity, motive, and 'the personal'.

Stories can be told at different stages in an interview account and can also contribute to some broader goal. In terms of Sacks's approach to storytelling, all of the extracts

analysed are set up to be heard as stories. The analysis of accounting practices at this level within the larger accounts has produced a number of implications for the study of satisfaction with health care which will be discussed later in this chapter (Section 3.3). The way in which these accounts are produced as assessments of health care experience will be discussed in the following section.

9.2.4 Producing assessments of health care experience in interview accounts

The interview accounts analysed here are set up as assessments of health care experience. This can be seen in all three of the main areas of empirical analysis. Taking a closer look at how this is carried out in the stories reveals how the assessments are used to appraise the behaviour of the speaker (IE), specific health professionals and health professionals in general. Regarding the latter, they are used on occasion to do both praise and criticism. The analysis has shown how the accounts are produced for the particular purpose of the interview. They are set up to be heard in this way (as assessments).

It has been shown how lay people structure their accounts, producing contexts and meanings locally. As Sacks (1992) suggests, experience is a carefully regulated thing. The interviewees set up entitlements to report on the experiences they describe, distinguishing personal from wider social experience (available in common with others). This is the case when making positive and negative appraisals of their experiences. Attention to such detail in the interview accounts counters a potential problem identified by Atkinson in his critique in his critique of narrative analysis:

> ...we are in the danger of recreating a new, individualized homunculus that escapes sociological or anthropological comprehension. (1997: 335)

In my examination of qualitative interviews I have taken the practical theory and commonsense knowledge used by members as the object of study, with the goal of producing sociological description in the way that Sacks (1963) proposes. The individual experiences described are set up as *social* experiences. The events described and assessed are located in commonsense knowledge of the social world. For example,

analysis of practical reasoning has shown how interviewees distinguish between different types of personal and societal experience, and how they use these in their accounts. This was seen in Chapter Four (Extract 4.2, page 105) where IE describes her personal emotional experience of her husband's death in relation to social expectations. It was also seen in Chapter Five (Extract 5.1, page 118) where IE sets up a social norm about nurses, 'nurses are in trouble' and uses this as a reason for not making a complaint. Reporting on personal experience involves setting up an entitlement to do so. The personal is constructed in relation to the social in these accounts. This was also seen in Baruch's study where the parents interviewed were seen to construct moral accountability for their actions.

The way in which social norms are set up and drawn upon in interview accounts ostensibly about personal experience, supports the point made by Goodwin and Goodwin which was discussed in Chapters Four and Five:

> Assessments (also) provide participants with resources for displaying evaluations of events and people in ways that are relevant to larger projects that they are engaged in. (1982: 181)

Assessments are a central feature of the interview accounts and assessments are products of participation (Pomerantz, 1984). We can see how interviewees constitute their individual experiences in relation to their membership of the social world, making them available for sociological analysis. This can be seen in relation to the extracts below (reproduced below from Chapters Three and Five).

Extract 9.2 (Interview 4, part of Extract 3.6, Chapter Three, page 87)

1 IE The only criticism I have with ((names hospital)) when (0.2) the sister asked me to go in
2 the office (0.2) doctor turns up forget what his name was obviously a (.) hospital
3 doctor (0.2) came in (0.6) and said 'there's nothing more we can do (0.2) your
4 husband has got a matter of (.) we don't know weeks or days to live' (0.6)
5 though you knew it (0.3) it was so cold (0.4) the sister sorta I just (0.2) it was because
6 it was just John Blunt (.) straight out (0.2) couldn't cope with that (0.2) I sort
7 of hypervent I just I remember it I just couldn't (0.2) and he just walked out (0.2)
8 → now I've got a criticism with that (0.3) I mean surely (0.2) er medical people whatever
9 (0.2) they can't just tell somebody they're going to lose their husband (.) and
10 then just walk out (0.2) I know he's a busy man (0.5) but (.) that is telling
11 somebody that their whole life's gonna change (0.4) and (0.4) I don't think (0.2)
12 → I don't know whether this comes in heh heh in the study but I don't think
13 doctors are trained to cope with (0.3) telling people (0.2) such tragic news=

Extract 9.3 (Interview 1, repeated from Chapter Five (Extract 5.1))

1	IE	(0.3) and about (0.7) half past six (0.3) two nurses came in she said 'you'll
2		all have to go out' (0.7) and I thought that was a bit odd and well course like
3		sheep we all went out (.) you know I should have told them to go (.) and get
4		lost (.) you know (0.5) and of course while (.) while we was out (.) god knows
5		what these two nurses did (0.3)
		(lines 6-12 have been ommitted here)
13	IE	and I wanted to stay 'til the end but you know (0.4) after we'd been out for
14		about half an hour (0.4) my granddaughter came up she said 'you'd bett:er
15		come back' (0.6) so I says 'has she gone?' so she says 'yes' (1.0) so why
16		those nurses did that I don't know I mean they (0.2) I thought that was
17	→	most er (0.2) unkind of em (0.6) but I I didn't complain you know (0.2) you
18	→	know don't wanna (.) nurses are in trouble as it is now without er (0.6) giving
19		em more trou[ble
20	IR	[mmh] (0.6) well in so[me yeah
21	IE	[but in er] you know (0.3) the lack of
22		Information amazed me (0.7)
23	IR	mmh=
24	IE	=because er you know (0.8) (coughs) I'm not trying to (0.2) make meself up
25		as a saint but (0.2) you know I struggled to (.) look after my wife for quite a
26		long time (0.5)
27	IR	mmh (0.2)
28	IE	and I lost a lot of weight (0.7)
29	IR	yeah (.)
30	IE →	and er you know (0.5) me mental capacity seemed to disappear as well (0.5)
31		cause normally I'm one of tho:se strict ones you know (0.2) [right is right]
32	IR	[mmh]
33	IE	(0.2) you know (0.6) but that (.) that that is er (0.6) most of it you know (0.2)
34		in a nutshell (0.5) the lack of information that was given to people =

In both of these extracts IE criticises the health professionals and provides initial grounds for making a complaint. In the first IE criticises the hospital for the way she is told that her husband is dying. In the second IE criticises the nurses for not giving him information about his wife's condition meaning that he was not with his wife when she died. However, in both of these extracts IE goes on to provide more contextual work to the criticism. In the first case IE goes on to provide possible extenuating circumstances

for the doctor's behaviour in terms of poor medical training. In this way she excuses his behaviour. In the second case IE, having made a case for complaint about the nurses' 'unkind' actions, describes his reason for not complaining as being supportive of nurses in general who are 'in trouble as it is'. He also describes the part he plays in the situation he describes, and provides extenuating circumstances regarding his own behaviour in not asserting his right to be with his wife when she died.

The analysis begins to reveal the complex work that is done by lay people in producing assessments of their experiences. They set up lay and professional identities with associated roles and reciprocal responsibilities. This was also identified by Cuff in his analysis of a family therapy session relayed on a radio station:

> ...what can be at stake in specifying appropriate identities for the parents is not simply the adequacy of their version, but also their adequacy as parents; the descriptions and 'the kind of person' involved in and/or doing those descriptions are 'reflexive' i.e. in hearing one, the other is made simultaneously available. Thus in producing their version of what is happening in the family, the parents can be heard simultaneously to be both specifying the identities of family members – what they are like – and to be addressing themselves to any relevant issues in such matters of blame, responsibility or criticism. In short, they can be heard to be displaying their descriptions as 'morally defensible'. (1980: 75-76)

There are similarities with Baruch's analysis of moral adequacy in the way his analysis examines how the experience of interviewees is constructed through (moral) accounting work. Attention to how the interview accounts are constructed makes it possible to observe the moral work being conducted by the participants, e.g. how they set up roles and responsibilities and consequently accountability for actions that arise from them. The construction of lay experience in these accounts provides some insight into how lay or patient views may be incorporated into patient-centred models of health care[158].

[158] The role of carers in patient-centred models of care is contentious and the particular role of the informal carer in health care during terminal illness will be considered in Section 9.4.

9.2.5 The construction of lay and professional knowledge

This study has shown how interviewees use lay and professional identities as a resource in their accounts. This can be considered in relation to discussions of lay and professional knowledge and expertise. The relationship between professional and lay knowledge has been hotly debated since Friedson's (1970) seminal text on 'professional dominance'. Discussion has tended to centre around the medical consultation, and differential power relations between patients and doctors (for example, see Byrne and Long, 1976; Barry et al., 2001; Charles et al., 1999). Efforts have been made by policy makers, academics and clinicians to attempt to rebalance what is considered to be professional dominance in the medical consultation, and to involve patients in decisions[159]. The doctor-patient relationship has consequently been the focus of considerable research and discussion.

The concept of patient-centred as opposed to doctor-centred medicine gained sway through the work of Balint (1964) and Byrne and Long's (1976) study of GP consultations. They emphasise improving the communication skills of doctors so that patients' experiences can be both expressed and addressed. Mishler's (1984) analysis of doctor-patient consultations identified two key discourses present in clinical interactions between doctors and patients, the 'voice of medicine' and the 'voice of the lifeworld'[160]. The medical consultations were found to be dominated by the voice of medicine, leading to the suppression of the lifeworld and medical dominance (in the consultation). Doctors and patients can at times use either voice and the discourse is shaped by the ways the voices interrupt and interpenetrate each other. Mishler argues that medical encounters that do not include the voice of the lifeworld are inhumane and ineffective.

On the basis of his analysis, Mishler calls for a form of consultation where there is an interchange of voices and the development of shared meanings. Silverman (1987: 198) highlights a number of problems with the position Mishler takes:

[159] There is a great deal of research and discussion regarding models of medical practice which promote patient-centred care. For example, see Stewart (2001), Stevenson et al., 2000; Elwyn and Charles, 2001; Silverman, 1987).

1. Medical interviews may well have *necessary* differences from ordinary conversations. The place of the 'voice of medicine' is not adequately considered.
2. Despite the stress on the importance of the relations between the two discourses, he appears to privilege the voice of the lifeworld as somehow being more authentic.
3. The call to move away from the biomedical model to a social perspective which gives primacy to the patient's various relationships, e.g. with family and at work.

Silverman goes on to argue that Mishler, along with Balint and Byrne and Long, attribute a certain authenticity to lay experience, or the lifeworld in medical interactions (implying that it has some kind of truth value in itself). They make recommendations on this basis, suggesting ways in which the voice of the lifeworld or patient view can be elicited by doctors. In Foucaultian terms this means that the patient or lay view becomes an extension of the medical gaze, and therefore the patient-centred model of care is not as liberating to the patient as it is purported to be.

Let us consider my analysis of lay accounts of health care experience in relation to the notions of the voice of medicine and the voice of the lifeworld. As Silverman's (1987) critique implies, Mishler and the patient-centred medicine movement implicitly apply a level of authenticity to the voice of the lifeworld. This is interpreted in an emphasis on training doctors in skills that will give the patient the opportunity to speak, so that they can know more about the patient and treat them accordingly. My analysis demonstrates how even in lay interview accounts where the voice of the lifeworld is given precedence, entitlements need to be set up in order to describe certain experiences and give opinions on those experiences. Regarding health care these entitlements are set up in relation to the roles and responsibilities associated with lay and professional identities. My detailed analysis of lay accounts shows that the issue of lay responsibility is set up as an

[160] Reference to Mishler's (1984) study is prominent in both the medical and sociology literature. For example, see Silverman (1987); Frankel (1999); Barry et al. (2001); Jones (2001).

accountable issue for lay people. This is often downplayed in research and discussions of patient-centred medicine and health care[161]. Although my analysis is of carer accounts rather than those of patients themselves, it seems likely that similar accounting work may be done. Further research on accounting work in patient (interview) accounts is needed.

9.2.6 A note on doctors, nurses and 'they' (the health care institution)

This analysis of interview accounts demonstrates the way in which lay people set up and use lay and professional identities in their accounts. There is not differentiation between the health professionals regarding level of expertise, e.g. medical and nursing knowledge. In these accounts the interviewees frequently refer to 'they' rather than particular professions, indicating that 'they' have access to this wider network of knowledge and information that the lay person is not part of. The sociology of health and illness has tended to distinguish between different professional groups, in particular doctors and nurses. However, in discussions of professional versus lay knowledge, there is often an implicit assumption that professional knowledge is medical knowledge, not nursing knowledge[162]. The way in which professional knowledge about health and illness is constituted (by lay people and professionals) as opposed to knowledge that doctors have, warrants further explication[163].

9.2.7 The interview as a site for the study of health and illness

The tendency to 'almost exclusively' concentrate on the consultation as a site for medical work has been criticised by Atkinson (1994). He argues that a great deal of medical work takes place in other settings where health professionals discuss health:

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[161] Although they have not actively privileged the patient-centred model, the extensive body of CA research on medical consultations has until recently also focused on the role of the professional rather than the patient (Drew, 2001; Beach, 2001b).

[162] This also appears to be the case in Baruch's data.

[163] For example, the British Sociological Association has a 'Medical Sociology Group' which covers the whole of 'health and illness'. A detailed discussion of this issue (of professional knowledge) is beyond the scope of this thesis but is one which requires further exploration. The point made here is that the interviewees in the data analysed here do not set up medical knowledge as distinctive from professional knowledge in general.

> ...there has been remarkably little attention to the social organization of everyday work and discourse *between* physicians, or analyses of medical work away from the face-to-face encounter between an individual client. Yet there is an enormous amount of medical work that is accomplished in the 'backstage' regions of medical settings, where medical practitioners consult with one another and with other workers.... Here doctor-doctor interaction, or doctor-nurse, or doctor-scientist interaction constitute contexts in which medical knowledge and professional judgement are formulated. The sociology of medical knowledge must therefore be attentive to the occasions and the forms of such discourse. It cannot be emphasized too much that such talk is not simply 'about' medical knowledge and medical work. It produces and reproduces that knowledge: it *is* the work (or part of it at any rate). (Atkinson, 1994: 118)

The point is made that professional judgements are not just based upon individual stocks of knowledge but are socially produced. This is supported by Strong who comments, 'No doctor claims to encompass all of medical knowledge. Each doctor has merely a small part of the wider whole, but each has access to all the rest through the profession...' (p30). This is also true of lay knowledge which has generally been restricted to the clinical encounter in CA studies[164].

Atkinson's interest is in medical knowledge and the sites in which it may be formulated and reproduced. Part of the rebalancing programme of policy and the sociology of health and illness, is an interest in lay knowledge of health and illness. Research on lay knowledge of health and illness in sociology may consider what lay people know about health, for example, their health beliefs (Davison et al., 1991; Calnan, 1987). Talking about public health, Popay and Williams (1996) argue for a greater emphasis on lay knowledge in understanding the meanings people attach to health and illness. Lay people are said to acquire 'expert' knowledge which is different from but (should be) equal to that of professionals (in public health).

[164] In a special issue of *Text* on 'lay diagnosis' reviewed by Drew (2001) and referred to earlier on pages 95 and 153, the one paper that did not use consultation data (by Beach, 2001b) studied telephone conversations between a terminally ill cancer patient and her family. Drew comments that it 'adds another important dimension to the holistic picture which is beginning to emerge of the connections between patients' experiences in their ordinary lives, and their accounts and explanations, and 'lay diagnoses' in clinical settings' (p265-266).

> ...there is a need to develop a much more reflexive understanding of the ways in which expertise - whether professional or lay – is structured. There is also a need for a more egalitarian perspective on the contribution that different forms of knowledge can make to our understanding, and the policies which could flow from it. (Popay and Williams, 1996: 766).

Two key implications arise from the call for better understandings of lay knowledge and expertise. They are that professionals and lay people have different amounts of the same knowledge, and/or that a body of lay knowledge can be built which is is different from, but complementary to, professional knowledge. In both cases it is inferred that there are differences between the knowledge that lay and professional people have (in either quantity or type). The rebalancing programme implies that there can be a redistribution of power. This means that in the consultation the patient will require the knowledge needed to make decisions that previously were the domain of the doctor.

The concerns of Popay and Williams with the structure of professional and lay knowledge raises issues about how such knowledge is constituted. Green (1997) draws attention to the situated nature of expert knowledge in late modernity. In a later paper she considers the status of expert knowledge in relation to evidence based health care:

> ...in the context of debates about evidence based health care ...such phenomena as 'knowledge', 'evidence' and 'practice' are not natural or necessarily distinct, but are constituted through local and contingent practices, and through the different interests of actors involved. (Green, 2000: 472)

Green also comments on the use of commonsense in relation to expert knowledge:

> Commonsense is a powerful rhetoric because it creates a sense of shared values between speaker and audience, which is difficult to resist without explicitly rejecting these values. It is also a device which constitutes expert knowledges as redundant, simply because what is said is self-evident and known by everybody. (2000: 470)

Green's comments can be seen to support the need to examine the 'local and contingent' practices through which commonsense and expert knowledge are constructed and used by both lay people and professionals. Such research complements Popay and Williams's

search for 'expert lay knowledge'. Taking up their arguments regarding the structure of knowledge, if we do not know how it is set up and used by people in local settings (in a range of circumstances), then the development of a body of expert lay knowledge will be based upon assumptions about its status, and consequently be open to inaccuracy (or be an artefact). Ethnomethodological analysis of accounts provides a method for examining how such knowledge is structured through local contingent practices.

In line with Atkinson's (1994) comments about studying medical discourse in a range of settings, it is argued here that this should also be the case with lay discourse (about health and illness). The prevalence of interview research on health means that it is an appropriate site for the study of the construction of health and illness as social phenomena. The interview is considered here to be a place where health and illness is produced in the form of lay knowledge.

The analysis of assessment work in constructing criticism in Chapter Five has shown how lay assessment of health care experience can be presented through expression of opinion. The notion of opinion as contrasted to knowledge provides in part for professionals to talk to laymen (Sacks, 1992). In sociological analyses of lay knowledge of health care experience, attention needs to be paid to the status given to the accounts by the interviewees. It is important that sociologists do not conflate lay opinion and lay knowledge in analysis[165]. As emphasised at a number of points in the thesis, this does not mean that, as critiques of ethnomethodology (Hammersley and Atkinson, 1983; Billig, 1999a; 1999b) have suggested, that we just gain an understanding about the structures through which people produce the social world. The interviewees demonstrate, as sociologists do in their research papers, through illustrative examples, the application of the structures to events. This application produces by-products such as criticism and praise. Through such analysis, we learn about how the structures are applied in order to produce social phenomena such as health and illness. As Schegloff comments:

[165] This also applies to studies of lay knowledge of health and illness in general, not just health care experience.

> If one takes conversational interaction among a society's members as one's domain (rather than characteristics of communication channels or linguistic structures exempted from daily use), then the major interest may be in the way alternative available formulations of objects allow the exploitation of members' analytic skills to accomplish a fundamental feature of everyday, organized social life. For it is through such resources that the production of a world of particular specific scenes through a set of general formal practices is accomplished and exhibited. (1972: 117)

One valuable outcome of an ethnomethodological analysis of interviews on health and illness, is that it can add to what we know about lay knowledge, through gaining a better understanding of lay accounting practices. For example, the interviewees here set up roles and responsibilities through categorisation work. They produce social identities but (in doing the assessment) set up lay identities in either a category set containing other lay people (Collection R) or lay and professional people (Collection K). These devices are used to produce some action, such as criticism of health professionals (or self). We can see how lay people use models in describing their experiences. It also demonstrates that analysis of lay stories (or narratives) does not necessarily produce the 'individualised homunculous' warned of by Atkinson (1997). It depends upon the theoretical approach taken.

The focus of this analysis is describing the resources that interview participants use in their talk, such as category collections R and K, and in examining how those resources are used to do certain activities. A central activity produced by interview partcipants is producing an assessment of health care experience. This has implications for health policy which will be explored in the following section.

9.3 Implications for health policy: from assessment to evaluation

We have seen that sociological interest in lay knowledge of health and illness through personal accounts of experience is increasing. A similar pattern is evident in contemporary health care policy, which reflects a shift from medical and government paternalism in health care provision (Toon, 1999) to a more democratic system with

greater patient and public involvement in decision making (Department of Heath, 1999b). Involvement of the public in health care decision making, from the doctor-patient consultation to the NHS Trust Board, is developing an increasingly high profile. It is partly justified by the perception that involving 'users' leads to improved service outcomes (Anderson and Florin, 2000).

This move towards greater participation by consumers and accountability of health care providers is evaluated through both quantitative and qualitative means. My analysis contributes to this area of health policy by producing a better understanding of the status and nature of lay assessments of health care by examining how they are constructed in interview accounts. Having described the assessment work carried out by participants I will now discuss the analysis in terms of its contribution to qualitative evaluation studies of health care experience. This will be discussed in relation to the increased emphasis on the role of the lay person or consumer in the evaluation of health care. Additional implications have been drawn regarding the role of informal carers in health care.

9.3.1 Evaluation of health care experience

The influential 'Griffith Report', which reviewed NHS management, made a case for evaluation of health services in terms of how well the service is delivered at local level (NHS, 1983 cf Dougall et al, 2000). Evaluation would be conducted through obtaining perceptions and experiences of patients and the community (Dougall et al., 2000), which has been translated into evaluation through patient satisfaction surveys (Williams, 1994; Williams et al., 1998).

As with most areas of the public sector, evaluation is carried out in order to find out what the need for services is, planning new services, seeing what works, and assessing the acceptability of services by the public[166]. It has been suggested that two rhetorics have emerged in health care policy (in recent years), the role and value of patient-

[166] Evaluation takes a wide range of forms from needs assessments, satisfaction surveys, outcomes (e.g. waiting lists; performance tables of surgeons). Equally a range of research methods may be used in evaluation research.

centred approaches to the provision of care, and the role and value of the patient in the evaluation of care (Fitzpatrick, 1996).

> The NHS needs to be a service which instils confidence and reassurance in those who use it. The most effective way to do this is simply to listen to what patients and the public have to say about health services and take their views into account when shaping local health services. (John Denham, Department of Health, 1999)

This has led to an increase in research on patient, carer and lay experiences, and efforts to develop patient-centred quality of life measures which are used to assess outcome (Fitzpatrick, 1996). Such evaluative research has primarily been quantitative, but the proportion of qualitative studies is growing. The increasing credence given to 'consumer' perspectives means that interviews in the form of surveys, qualitative interviews and focus groups are frequently carried out as part of evaluation. As mentioned in Chapter One, the increased interest in qualitative research has in part been fuelled by the growing demand for research which gives consumers a voice in developing services (Boulton and Fitzpatrick, 1994).

9.3.2 Studying satisfaction with health care

Contemporary health policy is concerned with the quality of health care provision (Campbell et al., 2000). This has led to many attempts to conceptualise and to quantify satisfaction quantitatively (Locker and Dunt, 1978; Williams, 1994; Fitzpatrick, 1996). However, these studies show high levels of satisfaction, which is considered a problem by those working in this area (Avis et al., 1997). There has consequently been a shift to exploring 'dissatisfaction' with health care (Coyle, 1999), and an increase in qualitative research on lay experiences of health care (Boulton and Fitzpatrick, 1994).

Coyle argues that problems with patient satisfaction arise because of the conceptual weaknesses of the concept. Furthermore, the concept of dissatisfaction is taken for granted in quantitative studies of satisfaction. Rather than being seen as a continuum by users of health services (from satisfaction to dissatisfaction), Coyle argues that this relationship is complex. Coyle's aim is to 'explore the meaning of 'dissatisfaction' with

health care (through the stories or narratives that people tell about their untoward experiences)' (p101).

Coyle identifies a core concept of 'personal identity threat' in her analysis. Interviewees' accounts demonstrated that their identity had been undermined or threatened in some way. She elaborates on the characteristics of 'personal identity threat' found in expressed perceptions of 'being *dehumanised, objectified, stereotyped, disempowered* and *devalued'* (p107). An aspect of this is that there is a consistent referral to practitioners breaking 'tacit taken-for-granted rules of lay-professional interaction' (p108). Coyle's point about lay-professional rules of interaction is useful. However, she does not show how these rules are set up, or how this is to be heard as an expression of dissatisfaction. This can be seen in relation to the data extract below.

Extract 9.4 (Mr Brown (24)). (Coyle, 1999: 109).

I'm getting a little disappointed with St Matthew's. At first they started off having a look at it. Took blood, did blood tests. Never did an x-ray. The doctor at Barrington asked about an x-ray after the 'rubber job' [colostomy]. Wanted to know why there was no water sample or x-ray. Now there's a shadow on the lung. We've given it a couple of months to see how it goes. Then go back again. See what happens, we need to wait till the papers come through.

Coyle uses this extract to illustrate a point that some patients 'objectified' themselves and wished to 'be scrutinised and subjected to medical processes and interventions' (p109). She comments:

> ...Mr Brown accepts the medical model of illness as separating the body from the mind. Given the uncertainty and fear which surround his symptoms, it may be that this perspective is more comforting. It may also lessen feelings of guilt as the malfunction of the body cannot be regarded as the responsibility of the mind or the 'self'. (p109)

Taking an ethnomethodological approach, we can see that the interviewee in Extract 9.4 starts to set up an expression of dissatisfaction or criticism[167] in line 1, saying he is a 'little disappointed' with the hospital. His criticism involves a level of caution. He sets up a lay-professional identity set that includes himself and the professionals at St Matthews. The professionals are attributed the responsibility for medical investigations. He mentions an omission, the lack of an X-ray. He also reports that the omission was observed by a doctor somewhere else. The way he locates his comment about the query by the doctor at Barrington (line 3) indicates that the doctor has implied a criticism of St Matthews in wanting to know 'why there was no water sample or x-ray' (line 4).

The way he presents this description makes it clear that the lack of an X-ray is viewed as a significant omission. It would not be significant on its own, but when related to the 'shadow on the lung' (line 5), and the query by the doctor at 'Barrington', it becomes so. Prefacing the report of the 'shadow on the lung' with 'now' also implies an association between the two indicating that it may have been prevented if the X-ray had been done, and that 'St Matthews' were not thorough enough. (This follows a similar pattern to Extract 3.3 in Chapter Three, where the interviewee relates the omission of an X-ray to a subsequent diagnosis of cancer, also implying that the hospital were not thorough enough.)

The status of the speaker's criticism in Extract 9.4 is therefore somewhat ambiguous. He is careful not to make this a direct criticism. He adds a description of his actions (and those of the other(s) included in 'we') in relation to the events recounted. He sets up the lay behaviour as reasonable in that despite their concerns they ('we') give it some time to see how it goes. This is presented as an active decision by lay members. Shortly afterwards he says that they 'need to wait' implying that this was the only option available to them. This also adds to the ambiguity of the criticism, in that doing criticism of others involves taking into account your own actions. As with my analysis

[167] I will refer here to criticism rather than dissatisfaction. It is acknowledged that the two terms are not necessarily inter-changeable, but this ethnomethological analysis of Coyle's extract is seen to contribute to an understanding of the notion of dissatisfaction and her concern about conceptual issues regarding the term satisfaction.

in Chapter Three, ambiguity is partly related to way the account is designed for the recipient. Although we can identify this extract and those discussed in Chapter Three as criticisms, all but one are indirect. As Drew comments:

> The moral work that speakers may manage through describing their own or others' conduct is very frequently deeply implicit or embedded in their descriptions in which case the moral evaluative "point" of an account may not come to be explicitly addressed by the participants in an interaction. (1998: 296)

When we take a close look at the accounts as in Chapter Three, we see that the speakers lay out the evidence and imply a criticism or expression of dissatisfaction, but the recipient has to decide whether it is appropriate or not.

Coyle raises some interesting points in her analysis, but she does make a number of assumptions in interpreting the data, which have implications for its application. The extracts are used to illustrate points rather than demonstrate their basis, and the relationship between the data and the analysis is sometimes hard to gauge. For example, although Mr Brown does not describe events in terms of emotional responses and psychological factors in Extract 9.4, Coyle interprets his account in such terms. In her interpretation of the Mr Brown's account she refers to a number of categories, 'body', 'mind', 'guilt', 'fear', 'uncertainty', and 'the self'. However, he does not talk about these issues in the extract given. This has implications for the problem she raises at the start of her paper about the conceptualisation of satisfaction (with health care). In order to conceptualise it, it is necessary to adequately describe how it is produced as a phenomenon in the contexts in which it occurs. As discussed in Chapter One, following Sacks, the aim is to produce sociological description that treats commonsense categories as features of social life, not as sociological resources. It demonstrates the need to establish the status attributed to accounts by the interview participants.

As discussed in Chapter Eight, when selecting the interview as a method of evaluation, the status the accounts are to be accorded needs to be taken into consideration. This status is actively attributed by the participants who produce a particular version of

events. If the evaluator wants to know what actually happens when say, people are given and receive care from health professionals, observation of naturally occurring events in situ will be a more appropriate method[168]. Interview studies such as this one enable the researcher to describe lay assessments[169]. This is in line with Locker and Dunt's (1978) comment:

> A true study of consumer evaluations of the quality of care would need to identify and employ criteria for standards used by consumers themselves. At the moment, consumers are used as sources of data about aspects of care predetermined by researchers as relevant for study. The role of the consumer in health care evaluations is then a limited one. (p290).

The analysis carried out here has gone some way to demonstrating the aspects of care made relevant by carers when producing a 'consumer' evaluation. We can therefore begin to see what criteria consumers set up and use in this type of evaluation. Through examining the resources used in their accounts, such as entitlements to experience, and lay and professional roles and responsibilities, the standards lay people set us for assessing their health care experience can begin to be described.

9.4 Lay evaluation

The analysis of lay assessment work in my interviews can be considered in relation to the literature on lay evaluation. Calnan (1987) proposes a conceptual model for analysis of the lay evaluation of medical care. It is based on three interrelated elements that may shape the way lay people evaluate medical care:

1. The socio-political values or ideologies upon which the particular medical system is based.
2. The level of experience of use of medical care.
3. The goals of those seeking medical help in each specific instance.

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[168] It is of course recognised that, 'The reflexive ethnographer will be aware that *all* classes of data have their problems, and none can be treated as unquestionably valid representations of 'reality'' (Hammersley and Atkinson, 1983: 138).

[169] Similar analysis could be carried out on professional narratives to consider the way in which they produce evaluations.

The contribution of my study to what is known about lay evaluation can be discussed in relation to Calnan's model. First of all, although lay people do not (formally) talk about 'sociopolitical values' or 'ideologies', the categorisation work they do in their accounts indicates an orientation to a particular form of social structure, where there are lay people and professionals who have differential roles and responsibilities relating to particular situations. Understanding the structural form of lay models of evaluation appears to be foundational and needs to be more fully explicated if the current trend for participatory models of health care delivery is to be successful:

> A transparent, responsive health service in which patients, carers, and the public are genuine partners is still some way off. Partnership requires engagement with people on their own terms, with a genuine sharing of interests. (Anderson and Florin, 2000: 1554)

My study indicates that the lay-professional model set up by lay people in their narratives has functions that need to be taken into account when developing policy. This is also supported by research such as Heath's (1992) study of GP-patient consultations where it was found that patients had an investment in constituting the GP as an expert - it legitimated their actions in seeking professional advice. It has already been noted that the research and policy literature reflect an assumption that professional dominance is set up and maintained by doctors. However, patients and carers also play a significant part in setting up professional-lay models of care. A more informed understanding of the relative functions of professional and lay expertise for both groups is required. Policy needs to be tied to lay (and professional) practices.

Regarding Calnan's second point, about the level of lay experience of medical care, the interviewees are seen in my analysis to consider this carefully in producing their accounts. Accounts are based on selected description and evaluations are based on opinion. This is made clear in the way in which assessment work is done. They set up entitlements to report on experience, differentiating personal from societal experience.

Calnan argues that patient evaluation of medical care can be understood in relation to the specific reasons for the patient or family seeking medical care in each instance, such that, 'Patients will make different demands and will evaluate medical care according to whether or not their demands are met' (p186). The accounts analysed here indicate that things are more complex than this implies. The interviewees (though they are carers and not patients) describe processes of events in which what is going on in relation to the illness is not clear, moves at varying speeds, and involves different people at different times. Such combinations of factors means that the term 'demand' is potentially misleading.

The accounts of the interviewees in this study indicate difficulties in negotiating relationships with health professionals, and as such appear generally to support other research in this area that has identified communication as an area of dissatisfaction with health care. However, analysis of these accounts shows that they do not set up their evaluations in terms of having made demands which were met or unmet. Rather, they are seen to do categorisation work to set up rights and responsibilities for the characters involved, including themselves (and the patient). This work indicates that it is difficult for people (patients and carers) to make demands of health professionals. It must be noted, however, that interviewees have made it clear that these accounts consist of selected events.

It cannot be known from these accounts, or this analysis, what actually happens at the times described, e.g. the relative distribution of areas of communication difficulty. Comparison between methods to assess the relationship between evaluative accounts, and observations of health care in situ, may produce useful insights. Drew et al. (2001) suggest that there is scope for comparing interview accounts with CA studies of doctor-patient communication:

> ...it may be possible in the future to integrate CA's methodology with certain external assessments of patient satisfaction. This might be achieved in a research design which combines detailed analysis of communication in medical interactions, with interviewing patients about their expectations concerning those interactions and how they felt those interactions were met –

> including, for instance, how satisfied they were with the role they played in reaching decisions about their treatment. Comparisons might then be made between interactions themselves and patient responses expressed in interviews. This would enable us to identify those interactional episodes which are associated with particularly positive or negative evaluations by patients. We could then begin to specify which communicative practices, evident in those episodes, are likely to result in patient satisfaction, and which results in their dissatisfaction (p69).

Concerns about the communication of information have been expressed here, as in other evaluations of health care (see Meryn, 1998). In criticising health professionals, interviewees may say that the lack of information or poor communication was a problem (for example, see Chapter Three, Extract 3.4, page 79; Chapter Five, Extract 5.1, page 118). However, such statements are qualified in relation to lay and professional identity work. An added dimension of this study is the position of lay carers vis-à-vis access to communication from health professionals. The analysis raises some implications regarding the status of carers in relation to health care. This will be considered next.

9.5 Informal carers

The contemporary policy literature *appears* to advocate an enhanced role for patients, carers, users, and lay people in decision making at all levels of the health service. For example, *Involving Patients and the Public in Healthcare: A Discussion Document* (Department of Health, 2001) states:

> Our vision is to move away from an outdated system of patients being on the outside, towards a new model where the voices of patients, their carers and the public are heard through every level of the service, acting as a powerful lever for change and improvement. To give effect to this, the patient must be at the centre of everything the NHS does. (p2)

However, when the principles of such involvement are set out, 'carer' as a separate category disappears and we are left with 'patients and the public'. Carers presumably now fall into the category 'the public', which has quite a different import[170].

[170] The use of language in such documents warrants detailed (categorisation) analysis.

The interviewees in this study can be referred to as carers for the purposes of discussing the policy relevance of the data. This is by no means an ideal term and the language used regarding carers and the people they care for is contested (Nolan et al., 1996) [171]. The term 'caring' as currently applied to interactions between families and those cared for has come about relatively recently (Morris and Thomas, 2001). Gubrium (1995) highlights limitations in the current body of literature on caregiving and states a need for more research on the lived experience of carers, including critical assessment. Nolan et al. also argue that more research is needed, especially qualitative studies which 'better capture the complexity and uniqueness of family caregiving' (p3)[172]:

> What is required is an empirically generated set of theoretical concepts which can help shape policy on a macro level whilst being sufficiently sensitive to inform interventions for individual carers and cared-for persons. (1996: 3)

Although health policy documents express a commitment to involving carers in decision making, the way this is to be carried out in practice is not clearly or comprehensively set out. This is exemplified in the lack of clarity regarding doctors' responsibilities towards relatives (Cawood, 2001)[173]. The Hippocratic Oath sets out responsibilities to the patient, but does not mention responsibilities to relatives. This means that the rights and wishes of the patient take precedence.

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[171] The UK government has recently produced a policy document specifically about carers, 'Caring about Carers' (Department of Health, 1999b). It states that, 'All organisations involved with caring must now focus not just on the client, patient or user – but must include the carer' (p6). However, this is primarily aimed at carers in situations where those cared for have a chronic rather than an acute or terminal illness.

[172] The term 'carer' in the policy literature also usually refers to carers of people with long-term chronic disabling conditions, rather than carers of people with terminal illness. Carers can be a family member or friend. All in all there is considerable ambiguity surrounding both the terminology used, and their role in health care decision making. Policy makers and researchers often seek to define 'carers' as a distinct group (Nolan et al).

[173] Attention to talking to relatives in communication skills courses for medical students is limited. The element relating to patients is about 'breaking bad news' (Cushing, personal communication). I have also looked through the books available on talking to patients and relatives in the medical library at Barts and the London School of Medicine and Dentistry. The emphasis is on talking to patients. There are some texts that include talking to families, but the emphasis is on breaking bad news. In a popular text by

> Talking to relatives is considered an important part of the delivery of good patient care, but it takes time. Not only does it disrupt already tight working patterns, but also it often requires care, experience, and sensitivity. It is not easy to conduct an emotionally demanding interview, while respecting the patient's rights to confidentiality and addressing relatives' questions (Cawood, 2001: 1375).

This medical position of patients' rights to autonomy was found to be supported by patients themselves in a qualitative study of cancer patients by Benson and Britten (1996). All the patients interviewed wanted doctors to respect their views rather than those of their family. Respect for autonomy was valued over benificence in terms of relatives' wishes for information. This presents an area of ethical difficulty for carers and health professionals. It may also be a contributory factor in the use of caution in their criticisms of health professionals. Making criticisms of health professionals becomes a delicate task if you have no official rights to information. The carer has to contend with both the expert knowledge of the health professionals, and the lack of a right to information unless sanctioned by the patient. This has some parallels with the way in which caution is used in criticisms of health professionals in the lay interview accounts studied here.

This provides some basis for understanding the lack of clarity regarding the participatory role of carers in health policy literature. It presents a challenge to medicine, medical ethics, and the social sciences, to consider the role of carers in models of doctor-patient shared decision making models. It is simpler to examine the issues in terms of dyadic consultation models or partnerships. The model advocated by Stewart et al. (1995) in their influential text on patient-centred medicine is notable for the absence of lay carers. The following passage comes at the end of the book:

Buckman (1992) the tone in the chapter on relating to relatives was quite embattled, along the lines of protecting the patient's interests against those of the family, e.g. 'Because of the frequency and intensity of reactions by family members, it is important to have some general principles when handling them' (p144).

> The changes we imagine in medical care, education, and research are rooted in partnerships: between patients and doctors; between medical educators and medical students and residents; between continuing medical educators and practicing clinicians; among specialities within medicine; among the health professions; and among researchers of a variety of backgrounds, both quantitative and qualitative. Let us move medical care forward by first forging true and egalitarian partnerships in practice. (Stewart et al, 1995: 232)[174]

My study of carer accounts sheds some light on how they negotiate and manage their rights and responsibilities in relation to their identities as members of the husband-wife, and lay-professional category sets. Carers constitute themselves in their accounts as having both responsibilities and rights regarding the patient and the health care providers. They have responsibilities towards their spouse, in that if they identify a potential health problem and the spouse does nothing about it, it is their responsibility to 'nag' their spouse to seek medical help (see Extract 2.1, Chapter Two, page 51). If already in contact with health services, it is their responsibility to monitor the situation and raise concerns with the health professionals (see Extract 3.1, Chapter Three, page 64). Raising such issues with health professionals may be constituted as a delicate task to perform. Regarding rights, there are situations in which membership of the husband-wife category set will take precedence over the lay-professional one. This was seen in Chapter Five, where the carer makes a clear case for being with his wife when she died. So, depending upon the context, they may be a lay member of Collection K, and therefore have to establish their rights and responsibilities within that category set. However, if, as in Benson and Britten's study, the patient does not wish the carer to receive information, they also may be outside Collection K, and have no rights to that information[175]. At the same time they may be a member of Collection R and have responsibilities to the patient. This examination of assessments by lay carers indicates

[174] It is of note here that 'patient-centred' in this approach puts the patient at the centre of a world of clinicians and researchers. Other aspects of the patient's life are not included in the partnerships.
[175] This may contribute to setting up lay-professional identities by carers. If the carer's rights to be involved in decisions is regulated by the patient, this may make it harder for the carer to challenge professional's. It would be interesting to do similar categorisation analysis of patients' accounts to see how they set up lay and professional identities.

that they support the notion in Cawood's and Benson and Britten's papers, that as carers they do not have an automatic right to information about the patient.

Gubrium (1995) highlights limitations in the current body of literature on caregiving and states a need for more research on the lived experience of carers, including critical assessment. The import of this part of the discussion is that the categorisation work members do in their accounts strongly indicates that the rights and responsibilities of carers are not static in assessments, that is, the carer does not set out a clear set of personal rights. Rather they are set out as context-dependent in such accounts. As situations change, as in different stages of the illness, so the rights and responsibilities of those involved are described as changing. This study has merely touched the surface of this issue, but it clearly indicates that it is an important one. If current health care policy advocating participation of carers in health care decision making is to be successful, the role of carers, and responsibilities of health professionals to carers needs to be clarified[176]. The commonsense reasoning of carers in interview accounts is a valuable source of sociological knowledge about this issue.

The following chapter will review the limitations of the present study and consider recommendations for further research arising from the analysis.

[176] It is also vital if the success of participatory models is to be assessed.

CHAPTER TEN

IMPLICATIONS

10.1 Introduction

This chapter considers the limitations of the analysis undertaken in this thesis in conjunction with a discussion of some recommendations for further research. The main limitations of this study are that a relatively small number of cases has been examined, and that the analysis has focused on selected aspects of members' work in the interviews. The implications of these limitations will be reviewed in relation to the outcomes of the study and to a number of possible areas for further investigation. Let us first of all reconsider briefly the nature of the current research.

This study was an analysis of qualitative research interviews concerning the death of a spouse. It demonstrated some of the detailed work that members do in producing the interview. Analysis of members' practices has revealed a number of resources that are set up and used in the talk to produce the accounts as assessments of health care experience. The analysis has drawn attention to the need to consider the status of interview data regarding the way it is produced by participants. This approach has revealed the research interview to be a rich and rewarding source of data on the accounting practices of participants. This richness may be missed in more conventional approaches to interview data. However, the emphasis on the detail of members' practices has a number of drawbacks which limits the application of the analysis.

10.2 Size of the data sample

Qualitative researchers often have to counter potential criticisms from quantitative researchers about the claims that can be made for their analyses given that the number of cases examined is often relatively small[177]. A large part of my analysis is based on five interviews which in some ways may seem to be a very small data set. However, the stance taken here is that the number of cases analysed depends upon one's analytic purpose. I will initially consider this in relation to the analysis of criticism and assessments where the main method used has been MCDA, before looking at the analysis of how the talk has been constructed as an interview (using CA).

[177] It is often assumed that quantitative studies require analysis of large numbers of cases. This is the case with survey research. However, research using experimental method may also be based on analysis of single or small numbers of cases. It depends upon what the research problem is.

Attention in the first three empirical chapters was given to the membership categorisation work which was carried out, primarily by interviewees. The analysis was detailed and 'fine grained' (Drew, 2001). The data have been analysed in accordance with the research problem (to describe criticism and assessment work respectively). My aim was to conduct a thorough ethnomethodological analysis of the extracts so that a level of analytic data 'saturation' was reached (cf Glaser and Strauss, 1965). This has contributed to producing a valid analysis. Part of this analysis has entailed demonstrating how the interviewees set up their accounts in such as way as to co-implicate the hearer (interviewer) in the production of activities such as criticism. The attention to the detail of members' talk goes some way to counter the promiscuity of MCDA that Schegloff (1992b) warns against. Analysis of the way the identities of the speakers are produced in the talk, using CA has also added to the validity of the analysis. These identities were not taken for granted and it has been shown that they influence the form the interview 'data' takes.

The construction of the identities of the interviewer and interviewee in the talk has been analysed using CA. The intention was to describe how this is done through the sequential work of participants and to identify formats and patterns across a larger number of cases (interview openings). The possibility of conducting detailed analyses of data and comparing sequential formats across large number of cases has contributed to the popularity of CA as a research method. Analysis can identify how utterances are presented and understood by participants. There is a built-in validity check in that, as demonstrated in Chapters Six and Seven, the collaborative production of phenomena in the talk can be identified through responses to utterances.

Hammersley (1992) points out that choices have to made when conducting research as to whether to opt for validity or reliability. Case studies such as this one aim for detailed analysis in the first instance which yield valid analyses of often relatively small data samples. The contribution of case studies is to greater understanding of particular phenomena, rather than the establishment of generalisability. Analysis of both

categorisation and sequential work by participants in this data has strengthened the validity of the analysis as whole but what about generalisability? I will consider this initially in relation to the sequential analysis of interview openings using CA.

Ethnomethodologists argue that the analysis of talk-in-interaction should begin with the 'technical analysis' first (Schegloff, 1997; Drew, 2001). It is also acknowledged that to be taken seriously by policy makers it is not enough to analyse single cases (Drew, 2001; Heritage, 1999). In order to generalise analysts need to see whether similar patterns are found across much larger data sets. Sequential analysis of large data sets is a feasible and useful way of establishing the reliability and therefore generalisability (for example, see Heritage et al., 2001; Heritage and Stivers, 1999). The analysis of the interview openings in my study has involved the examination of a larger number of cases. However, the decision to examine further cases was tied to the research problem studied. The selection of further cases was therefore guided by analytic concerns.

The analysis of these interview openings has shown how the interviewer and interviewee produce recognisably 'open-ended' questions and responses. It would be valuable to look at other places in the interviews to investigate this collaborative work further. One way of doing this would be to examine the way in which the transition from the 'story' to the rest of the semi-structured interview is done. This would add further instances and allow comparisons to be made with the analysis of the interview openings.

Analysis of the interview openings has also demonstrated how both interviewee and interviewer actively engage in producing the interview. The skill of the interviewee in producing the answer the interviewer wants to hear, the danger of which Fielding and Thomas (2001) warn would be qualitative researchers, is something that requires further explication. The skilful way in which the interviewee 'finds' the right response to the open-ended question put by the interviewer calls into question the 'expert' status of the qualitative researcher (relative to that of the interviewer). This analysis indicates that further research is required across different data sets to explore the collaborative

construction of qualitative interview data. The need to examine communication in interviews and the construction of identities has particular relevance at the present time when policy makers are making moves towards participation models in research as well as in areas such as health care[178].

The analysis of membership categorisation in the interview data has been followed through from the preliminary analysis of how the accounts are produced as reasonable, to analysis of criticism and assessment work. Comparison between cases has been carried out (at different levels), and has also been made with data from other sources (notably, Coyle and Baruch). Further analysis of cases from the data set (the 65 interviews available) could be conducted to establish patterns in the way in which categorisations are done. However, it is to be noted that such analysis is labour intensive and decisions need to be taken about the research focus. Another course to take would be to compare the work that members are doing in my data, e.g. setting up lay and professional identities and entitlements to describe certain experiences, with other data sets where accounts of health care experience are produced. Given that Sacks has documented these practices in everyday conversation, it seems likely that they will occur in other data contexts beyond this dataset. For example, the value of exploring the notion of entitlement to experience is potentially valuable as such entitlements appear to influence what can be talked about by interviewees. Given that little is known about what determines lay evaluations of health care (Jung et al., 1998) this would seem to be an area which warrants more detailed explication.

Another aspect of the categorisation analysis which has been of particular value in this study is the use of Collection K and Collection R by the interviewees in their descriptions of health care. The applicability of these two category collections in these accounts indicates that they may be observed in similar types of account, and in other institutional settings where lay and professional relationships are described.

[178] For example, a body funded by the Department of Health, 'Consumers in NHS Research' has recently been set up to encourage and support consumer involvement in the design and conduct of health research. See www.conres.co.uk.

The current study can be seen to add to the small but growing body of research applying MCDA to interview data. However, the small number of cases analysed does mean that the generalisability of the analysis is limited. The advantage of analysing data across a range of cases is that the practices of different population groups can be compared. Analysis of more cases would enable the examination of different activities in the talk, such as the production of gender.

In my preliminary analysis of the data gender was identified as a possible issue to explore. In her recent study of informal caregiving by family members of older relatives, Paoletti (2001) has examined how caring is constructed in interview talk and its relationship to gender categories and moral identification work. A key finding is that interviewees:

> ...display an orientation towards the production of a moral order in which duty and responsibilities are allocated on the basis of gender distinction. Males are generally described as not being responsible for caring tasks, except for situations in which females are absent or sick, that is, for "serious reasons". (Paoletti, 2001: 293)

The notion of gender could be developed further in my interview data to see whether, and how, orientations to gender are constructed. A clear orientation to gendered caring can be seen in Extract 2.1 (page 51), where the interviewee identifies herself as a 'nagging wife' who tells her husband to 'get to the doctor'. The investigation of gender in these interviews would require analysis of a larger number of cases. Even when interviewees do not formally establish such actions as gendered (as in 'nagging wife), comparison across a larger number of cases may allow patterns to emerge.

10.3 Topics *in* the talk

Another possible limitation of this analysis is that its focus is on detailing the work that interview participants do in producing the talk. This means that it would be misleading to categorise it as a study about 'death and dying' or 'cancer'. It has not set out to produce a research account of death and dying, cancer or bereavement (although it is

hoped that those interested in these topics will draw insights from the study). This analysis cannot say specific things about the experience of the death of a spouse from cancer, or whether people prefer to be with their husband or wife when they die. However, it offers different perspectives on such experiences, such as how people set up and use entitlements to certain experiences and actions. The entitlements do not prescribe actions but do provide insights into the experience of a spouse dying from cancer. I argue therefore that this analysis of accounting practices can be used to inform the study of lay evaluations of health care, and more indirectly what is known about terminal illness and the role of family carers.

In addition, although certain activities have been observed in the talk and described, notably criticism (and praise), the aim of this analysis has not been to provide definitive accounts of these activities. They are as Sacks puts it, by-products. It is possible to say some useful things about they way lay people criticise health professionals. However, it is not possible to identify the status of criticism in relation to other phenomena going on in the talk such as praise. The analysis has shown that in this interview data doing criticism and praise involve setting up lay and professional accountabilities. Both of these issues would warrant more detailed study. The construction of praise of health care professionals appears to be a phenomenon which is generally under-researched and may provide useful insights into how care is assessed. Analysis of instances of praise in this data set could be examined, and/or comparisons made with other data sets.

10.4 Sacks and storytelling

It has been argued in Chapter Nine that Sacks's work on storytelling contributes different insights into the analysis of qualitative interview accounts. This will be considered briefly here in relation to other ways of treating interview data. Taken simplistically three main ways of examining qualitative interview accounts can be identified. They are all about identifying patterns in the data but each approach offers a different conception of the research problem. The conventional approach is to identify and describe themes. Thematic analyses can vary in depth, depending upon the

approach taken. The second approach, which is gaining popularity in sociology, is to treat the whole account as a narrative and to describe it in terms of the structure of the story, or its plot. Labov's (1972) approach is commonly used as the starting point for such analyses, where a number of stages (not necessarily consecutive) are identified (Reissman, 1993). These stages include: abstract, orientation, complicating action, evaluation, resolution and coda. There are of course many forms in which both narrative and thematic analysis may be applied, some of which were discussed earlier in this thesis (see Chapter One and Chapter Nine). They are presented in this way here so that the alternative approach offered by Sacks and ethnomethodology can be discussed.

Sacks's approach to the analysis of stories is based on ethnomethodological principles. Rather than considering stories in terms of themes or overall plot, attention is paid to the interactive work through which the accounts are produced. As demonstrated in my analysis, even when there is just one person doing most of the talking, the speaker can be seen to design their account for the hearer. The collaborative production of the talk can be seen in a different way in the interview openings where both participants in the talk orient to the production of a particular form of account.

Attending to the analysis of interview accounts using the methods of MCDA and CA opens up a whole range of activities for the analyst that would not otherwise have been observable. This includes types of categorisation, the use of ambiguity in producing cautious criticisms, entitlements to describe certain experiences, and the skills of the interviewee and interviewer in producing the interview data. In this way Sacks's work offers an alternative approach to the analysis of stories or narratives which can arguably avoid some of the problems with the study of narrative which were discussed in Chapter Nine. Further research applying Sacks's approach could be undertaken on different forms of narrative and comparisons made between the types of work that members do in them. For example, are entitlements to describe certain activities consistent across accounts about different issues?

Although it did not start out in this way, this thesis has become a study of the status of qualitative research interview data. The prevalence of interviews in contemporary society means that they are an important site for the production of knowledge about the social world. This analysis has shown the value of treating interview accounts as the topic of study and in describing in detail some of the accounting practices of participants. It demonstrates the value of interviews as a valuable source of sociological data. However, this analysis has revealed that interview accounts are constructed through complex interactive practices and need to be handled with care.

Postscript[179]

Interviewer: The question, I'm sure, is asked you many times - you may be tired of it – someone comes up to you and says: "This is not really a Negro play; why, this could be about anybody! It's a play about people!" What is your reaction? What do you say?

Hansberry: Well I hadn't noticed the contradiction because I'd always been under the impression that Negroes *are* people. But actually it's an excellent question because I do know what people are trying to say. They're trying to say that it isn't a propaganda play, that is it isn't something that hits you over the head; they are trying to say that they believe the characters in our play transcend category. However, it is an unfortunate way to try and say it, because I believe that one of the most sound ideas in dramatic writing is that in order to create the universal, you must pay very great attention to the specific. Universality, I think, emerges from truthful identity of what is. In other words, I have told people that not only is this a Negro family, specifically and definitely culturally, but it's not even a New York family or a southern Negro family. It is specifically Southside Chicago.... that kind of care, that kind of attention to detail. In other words, I think people, to the extent we accept them and believe them as who they're supposed to be, to that extent they can become everybody. So I would say it is definitely a Negro play before it is anything else...

Lorraine Hansberry, *A Raisin in the Sun* (1959/1988).

Well finally all of the geniuses were present at last, and the way the conversation worked out was really remarkable. Because, the first one genius said to another, "What was that screamingly funny remark you made last Tuesday?" So then *he* told it and they all laughed. And then it was *his* turn to ask, "And what was that terribly clever thing *you* said on Friday?" So then the other genius got *his* chance, and it was all give-and-take, so that everybody had an opportunity to talk about himself.

Lorelei's observations on turn-taking by geniuses. Anita Loos, *But Gentlemen Marry Brunettes* (1928/1989)

[179] I include two quotations as postscripts rather than at the start as is the norm. They are by creative writers rather than sociologists but I believe they sum up what it is about Sacks's work that has inspired me. Even though they were writing before him and for different audiences they are interested in the same thing, producing detailed observations of human life.

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Appendix 1 – Letter to potential interviewees

Dear

I am writing to ask for your help with a study we are making into services provided by hospital and hospice for people with cancer who have died and their spouses in South East London. We would like to hear of any experiences, good and bad, encountered at this very difficult time, so we can plan better care for people in the future.

If you agree to take part I will visit you to discuss the care you and your spouse have received, for example how satisfied you are with the treatment which was given. It is expected that the interviews will last between 45 minutes and an hour.

I appreciate that this may be distressing for you to consider at this time, and that you may consider that you do not want to take part. It is entirely up to you whether you take part or not. If you are willing to help with this study, I will arrange a convenient time to come and talk to you. If you do not wish to take part in the study, please contact me and I will make sure that you are not contacted again.

If you do decide to take part, all your answers and comments will be completely confidential. Also, you may stop the interview at any time if you wish to.

If you have any questions about this study, please feel free to telephone me beforehand.

Yours sincerely,

Moira Kelly BSc RMN MA
Research Associate

Appendix 2 – Summaries of interviews 1-5

Summaries of the events described in interviews 1-5 are given below[180]. The analysis in Chapters Two to Five is based on analysis of these five interviews. The interviewee is referred to as IE and the interviewer as IR. The places where extracts have been included in the chapters are marked. Where marked the extracts are labelled according to the chapter number and place within the chapter, e.g. Extract 3.1.

Interview 1 (Male, wife died in hospital)

IE begins with 'it goes back quite some time about five or six years ago on a day like this pouring with rain'. His wife goes down to the village despite IE making a comment that she would be mad to go out in the pouring rain. He gets a phone call to say that his wife has collapsed in the street and that an ambulance has been called. IE gets there in time to go to the hospital with his wife in the ambulance. She looked terrible. He waits in the waiting room with no information while his wife is taken to be examined. He waits for an hour and a half before asking a nurse what has happened and is taken to see his wife. She was sitting up 'looking bright and perky'. A doctor comes along and reports that the examination has not found anything untoward (see extract 3.3). He then comments that he thought this was odd as she was not given an X-ray. He describes a case about an American who developed cancer but who did have an X-ray. He sees this as the 'lead off' off his wife's 'troubles'.

She was well after this until Christmas when his daughter commented that his wife looked tired. He describes how she was still working implying that she should have stopped. He then describes telling his wife to stop smoking but she wouldn't, 'she smoked and smoked and smoked'. He comments that he thinks it causes cancer. After Christmas he noticed that his wife was getting slower and more easily tired. She then

[180] The stories are taken to be at an end when there is an indication that the story has ended by the interviewee, such as a verbal indication like 'that's it' or a long pause which is followed by IR coming in with comments referring to the end of the story.

gave her job up. Later in that year her left hand 'was always going cold' which was painful. They went to see her GP who referred her to hospital.

She was referred to a consultant, but saw his registrar. He did not go in to the appointment with his wife and comments that she was 'a dab hand' at not telling anybody anything. Later she saw another hospital doctor who prescribed some patches which had a lot of side effects. When informed, the GP said to stop them straightaway. He is very specific about the dates of the patches. She then went for an ultrasound and a chest X-ray. He comments that he and his children were given no information at this time. At a later appointment he sees the consultant who prescribed the patches, with his wife. She complains about them saying they had made her ill. The consultant says that the patches were not causing the problem, but 'its whats in your chest' that was. IE comments that at this point no effort was made to contact a chest specialist or to get urgent X-rays. IR asks at this point what type of doctor they saw and IE responds to the query, checking his notes. She then went for a sputum test and was waiting for a chest X-ray appointment. Another query by IR here about the chest X-ray and information received which IE deals with. Antibiotics and vitamins were prescribed by her GP.

She was then admitted to hospital, having been referred by the GP, and had a chest X-ray. She was under a different consultant during this admission. She was then transferred to a different hospital for three days (with better equipment). The surgeon she saw there explained that she had a tumour which was beginning to go into the right lung. IE comments here that 'still nobody said what the tumour was', and that 'of course you know in retrospect'. Later it all fitted into place raising the question 'why was I so blind?'.

His wife went home from hospital and one morning IE noticed blood on her pillow. When he asked her about it she would not say much about it. The GP was called and he

got her admitted to hospital again. She went to a separate hospital for a biopsy and then went back to the other one. The consultant came round with his assistants, 'I was sort of

like pushed out of the way' and the curtains were drawn. When he came out he told IE that his wife had a massive tumour on her chest. He then describes that he should have demanded to stay with his wife when she saw him, as he (IE) was looking after her. However, he was in a 'poor state of er awareness' at the time.

His wife went home for a month. She then went to a specialist cancer hospital as an outpatient for radiotherapy. She had two visits, but died before she had the third. She went into hospital following a visit from the GP. The day before she died she was still at home and IE planned to stay up with her all night. However, his granddaughter who was a nurse at the hospital came round and said that he had to go to bed. He went to bed at 9pm and at 10pm his granddaughter woke him up saying his wife wanted to see him. She was sitting on the edge of her bed and he put his arms round her. He then cries and apologises. IR apologises to him and says it's a difficult thing to talk about. He then carries on, saying he gave his wife a cuddle.

The GP was called and he called the local hospice but there was no doctor on so a bed was found at the hospital. He was made to stay at home despite his protests. A call comes to go in urgently and he and his family go up there. She was sitting up in bed in a side room. She recognised them and talked about things that had happened when she was a child, and a joke they had between them. Her last word was his name. He and his family were then asked to go out by two nurses (see extract 5.1). He describes thinking this was odd, but they responded by going out of the room 'like sheep'. While they are out of the room his wife dies. He describes how he thought this was unkind of these two nurses, but does not complain. He describes how his mental capacity 'seemed to disappear' during that time otherwise he implies he would have fought to stay with his wife when she was dying. He sums up his story with 'the lack of information that was given to people'. This is the end of the story.

Interview 2 (Male, wife died as she arrived at the hospital)
IE begins with 'well basically erm well I retired in 1985'. His wife was asked to go for breast screening with her friend. Her friend was given the all-clear but a lump was found on his wife's breast which was though to be benign. However, it turned out to be malignant and she had an operation. She then went to a specialist cancer hospital for 'X-ray' treatment, every day at first and then less because she improved. Eventually they only went for an annual check up. During this time they got to know the specialist hospital well and IE describes them as doing a 'marvellous job' and being very kind. This is unlike some other hospitals (no names given). IE then starts to become tearful and IR apologises. IE carries straight on saying that they were 'very lucky' as they had another nine years. He begins to become tearful and apologises. IR apologises and says that it's a very difficult thing to talk about and they can stop if he would like to.

IE just carries straight on saying 'Anyhow I say we got around and visited friends'. They made the most of things but after a while his wife began to get backache. She carried on doing keep fit twice a week which did her good. He describes the class she attended. Then about a year before the interview she went for the last time as the apin across her back got too bad to go and they went to the doctor. She had X-rays which did not show anything up. When they went to the specialist cancer hospital for their annual check a month later IE's wife mentioned the pain in her back and yet another X-ray showed nothing. This time she had an MRI scan. IE describes the scanning equipment which was 'a bit Heath Robinsonish looking', and the process in detail, laughing at times. They found 'a cell or something or other in the spine' which was cancer having 'come across' when she had lymph glands removed in her initial operation. She had to wear a rubber armband to help the fluid disperse which may have caused the cancer cells to move into her spine. This is how IE interpreted it. He then describes how in the end she had no control over the bottom half of her body. He then goes back to the time of the scan. IE and his wife asked if it was operable but they were told it was best to try more X-ray treatment for 10 consecutive days first. This was done as an outpatient at the specialist hospital, but did not work unfortunately.

IE's wife's condition deteriorated and she lost the use of her legs, becoming bedridden. IE then becomes tearful again but carries straight on. He describes how his wife did not want to go into hospital thinking she would never come out. A bed was fixed up downstairs. District nurses would come in to care for her. A hospital bed was provided and a hoist and various other equipment. IE laughs when saying that 'In the end I had half of [names hospital] in here'. He describes the district nurses as 'marvellous'. He comments that this (the care) went on for quite a while. He then talks about an elderly relative of his wife's, and how she came to stay with them for Christmas the previous year. His wife was still walking then and walked across a field to see a little foal. The relative died around the time his wife started to become unwell which upset her a lot. IE then becomes tearful again. He describes these family relationships and ages. He comments that his wife was expecting him to go first as he was older than her, laughing again.

IE then goes back to his wife's illness, to the day she died. She was in bed and he describes their daily routine. He would prepare her breakfast and he and his son would sit her up. That morning she could not help pull herself up but she had an extra cup of tea and seemed quite cheerful. She had a good night but was now in a lot of pain across her back. IE talks about her 'pills'. She was given a lot of pills but he says she did not take her life (part of this was not clear on the tape). He describes keeping a good check on the pills and taking most of them back to the chemist later. Later that morning the nurses arrived and they and his wife were chattering away. He then talks about the woman who came to do some cleaning who was also there. He decided to go out for a paper as his wife seemed happy chatting to the nurses. He saw a particular chocolate bar his wife liked, saying 'it's the soppy things that stick in your mind'. He got her two of those for later. When he went back she was still chatting to the nurses.

IE went to tell the woman who did the cleaning that it was time to pick up her children and at that point a nurse said he should come quick as his wife could not breath. He called an ambulance and though she was still breathing at this point, she was in a coma. They said they needed to take her to hospital and asked if he wanted to go. He then

describes in some detail that he had various people coming round about things and could not go. He is called a short time after this and is told that nothing could be done and that his wife had died. He was asked if he wanted to see the body but said no. He gives reasons for not doing this and then said, 'but I couldn't go to see her again. I just remember her'. IR comes in here saying that he had a lot of really good memories. He said that they had many happy years. IR comments that it is a very painful experience. IE says that he would not want anyone else to go through it and, 'she fought hard but she didn't make it'. This is the end of the story.

Interview 3 (Female, husband died in the hospice)

IE begins with 'he started off with an ingrowing toenail'. This is what her husband thought he had, but despite five lots of antibiotics it was no better. He did not do anything about it for five months so IE eventually makes him go to hospital where they gave him a local anaesthetic in his toe. When back at home he manages to sleep after 10 sleepless nights in a lot of pain. However, she has to take him back in to hospital at 2am. This time they did 'about 12 tests'. While all this is going on she overhears a doctor mention a 'lesion on the lung' to a nurse (see extract 3.1). He was admitted and had investigations which found a blockage in a groin related to the pain the toe and a bypass is recommended. She mentions the lesion on the lung to the health professionals and a biopsy is then carried out along with a scan.

A tumour was found and they (husband and family) are called in for the results, but the results were not there. They went back in eight days to a different hospital and saw a consultant who apologised for not getting the results before. IE and her husband, alone this time, were told that, despite the lack of symptoms, he had a large tumour which was operable. IE's husband asks IE what he should do. She says she cannot advise but can be his 'backbone'. He asks for a second opinion from a consultant at a specialist cancer hospital who says to 'go for it'. The operation goes well (see extract 4.1). He has his bypass 16 weeks later and two toes amputated. He was fine for a while, but then develops pain in his lung. Morphine is suggested. He becomes vague around this time and IE gives an example.

He was admitted to the hospice for some treatments and tests. This does not improve things and the doctor sits down with us (IE and her children) and talks to them which had not been done before. The implication is that they were told about the prognosis although she does not say what was talked about. He stays in the hospice until 'he passed away'. She gives the date and says 'so that's it'. This is the end of the story.

Interview 4 (Female, husband died in hospital)

IE begins with 'its about this time last year and my husband he had flu coming on' (see extract 2.1). She nags him to go to see the GP as it was not clearing up. He then started to lose weight and goes again to the GP. He noticeably loses more weight and feels very cold. She then goes to see the GP herself as she is not happy. She then says 'to cut a long story short' and describes her husband being referred to the hospital chest clinic where he sees a consultant and has an X-Ray. By this time he feels very ill. He was given some antibiotics. She describes him having been given no treatment by the GP until this point, even antibiotics. Her husband seemed to improve, but when they went back to the consultant three weeks later another X-ray revealed that the tumour had grown (she does not describe being given the diagnosis). He is referred to another hospital and has an operation to remove part of his left lung. The operation was considered to be a success and the discharge papers said 'no complications'.

All seemed to be well until a couple of months later when IE's daughter finds her father collapsed at home. IE goes home and calls the GP who says to call an ambulance. He was conscious but very ill. He was taken into hospital, kept in and never went home again. He died within about four weeks. IR asks if this was in the local hospital (names it). IE then carries on to describe her husband's experience after being taken into the local hospital. She says the care in A&E was excellent. He was then transferred to another hospital (the third one mentioned during this story). IE then describes in a vague way being informed that his condition was serious, 'they said 'ooh' they didn't sort of say in so many words'. She reflects that this may have been because she did not want to know (the prognosis). However, 'on reflection it was obvious you know you

had that sixth sense that there was something wasn't right'. He had two operations on his spine to which he responded very well. She remarks that his response to three operations in three months as someone who had never had a major operation before was particularly good. This gave her hope.

He then went back to the local hospital where he was going to start physiotherapy. A nurse who was probably cancer trained went to see them and told them fairly 'bluntly' that he had cancer, but that he would be 'alright' and they would be able to control it. IE said they already knew, but said her husband took it remarkably well and was upbeat about it. He was then transferred to a specialist cancer hospital (fourth hospital) for a week's radiotherapy. IE comments that the hospital was wonderful but she was not given any information (see extract 3.4). She does not know what her husband was told. He then went back to the local hospital where IE describes a criticism with how she was informed that her husband was dying (see extract 3.6). She criticises the blunt way she was told and how the doctor then just walked out but does say that she thinks that doctors are not trained to cope with telling people 'such tragic news'. Despite being told her husband was dying she said that she knew all along.

She then describes the care as very good. Some Macmillan nurses went to have a chat with her and she asked if she could have him home for his 'final days'. They said to see how he goes over the weekend (in the hospital) but he died on the Saturday. She felt they knew he would. She was offered a lot of bereavement counselling afterwards but she did not want it. She was keen to get back to work. She describes herself and her daughter being stunned and mourning. She then describes being with him when he died which she was grateful for (see extract 4.3). She then went on 'automatic pilot' though she has her 'moments'. This is the end of the story.

Interview 5 (Female, husband died in the hospice)

IE begins by describing how her husband was diagnosed two years before he died which 'was a great big shock'. They had gone to see a GP at the health centre for the result of an X-ray and were not expecting there to be anything wrong. He had no symptoms such

as pain. The 'strange doctor' (a locum) just said 'I'm sorry you've got lung cancer'. They walked home in a daze. IE then describes her husband as having panic attacks related to an experience during the war. They were told that the cancer was inoperable. They queried possible causes of the cancer including smoking. He was told it was not related to smoking even though he did smoke. They were told it was unlikely to be related to his job as an asphalter. She describes 'people' having told her of knowing people who have been asphalters who have died from lung cancer, saying that 'I would have thought it might be'.

Her husband did not get any pain, even at the end, which was 'a godsend'. She describes the local hospital as being 'excellent'. He went for an outpatient appointment and they kept him in. They put him on steroids which made a major difference, helping him to 'sort of erm live properly again'. IE then talks about him coming home twice from the hospice (though she does not describe how he came to be admitted to the hospice). She was pleased about this because it had been difficult not being able to cope with looking after him at home. Turning was the most difficult part. She describes the lack of concern from the health centre who she said do not assess and take account of the needs of carers in looking after someone so ill at home. Her husband developed symptoms that looked like a stroke (see extract 3.5) and it was suggested by IE (and her family) that it might be a stroke to the GP. The GP says 'it would seem so' apparently confirming the lay diagnosis but it turns out to be a sign that the cancer has reached the brain, 'as it did with Roy Castle'. She gives a reason for the initial lay misdiagnosis, 'we're not medical people are we?' Again she comments that her husband was very lucky not to have had pain. She then describes discussing some leaflets on cancer with her husband and whether to contact the numbers suggested for help. He did not want to contact anyone. He then went into the hospital where they were 'ever so good'. She describes how there were only two nurses on for 30 patients but they still did everything they possibly could. One of the nurses even got her husband a side room when she found out he had panic attacks. He was transferred to the hospice where the care was very good. They have a lot of 'helpers' and nurses and can do anything the patient wants. She describes it as an 'excellent' place. This is the end of the story.

Appendix 3 – Transcription notation and presentation of data in the text

The conventions used for my transcripts are derived from those developed by Atkinson and Heritage (1984) and are listed below. They denote gaps between utterances and overlapping talk and other sounds.

IR	interviewer
IE	interviewee
( )	words spoken that are not audible
[	two speakers' talk overlaps at this point
=	no interval between turns
?	interrogative intonation
(1.0)	pause timed in seconds or tenths of a second
(.)	small untimed pause (less than two tenths of a second)
:	prolonged consonant or vowel in a word
heh heh	laughter
.hhh	audible in-breath
hhh.	audible out-breath
(( ))	transcriber's description
[((	transcriber's description of sounds overlapping with speaker's utterances (where such sounds are transcribed they are included in an unnumbered line immediately below the speaker's utterances).

The level of detail included in the transcription differs between the chapters. Transcription is not a neutral process but is part of the analysis and interpretive work (Ochs, 1979 cf Paoletti, 2001). This is reflected in the way my analysis has proceeded through a number of analytic problems that have required different levels of detail in the transcription of the interview data. The transcription has become gradually more detailed as the research moved through the three pieces of analysis (criticism, assessments and interview talk). The early analysis included in Chapters Two and Three

is based on a relatively crude transcription of the data. Pauses between utterances are recorded but relatively little other notation included. In Chapter Three analysis was undertaken of the categorisation work going on in the talk and the level of transcription was appropriate to needs of the analysis. However, in the subsequent work a more detailed analysis was undertaken of the construction of the talk and therefore the notation is necessarily more detailed.

The initial request is also included with the extracts the first time they are presented in Chapters Three, Four and Five. The time between the request and the extract, and a brief description of the topics described prior to the extract are also reported in italics. Line numbers are not included in the opening request as the question is there for information only (and to avoid confusion).

Appendix 4 – Use of appositional beginnings in interviewee first responses to the interviewer's request

Interview number	'Yes', 'Well', 'Yes well', 'yeah'	Insertion	Repetition
1	Y		
2	Y		
3	N	Y	
4 No Q	-		
5	N	Y	Y
6	N	Y	
7	N		
8	Y	Y	
9	Y	Y	
10 No Q	-		
11	Y		
12	Y		
13 No Q	-		
14 No Q	-		
15	Y	Y	
16	N	Y	Y
17	N	Y	Y
18	Y	Y	
19	N	Y	
20 No Q	-		
21 No Q	-		
22	Y	Y	
23	Y		
24	Y	Y	
25	Y		
26	Y	Y	Y
27	Y		
28	N	Y	
29	Y		Y
30	Y		
31	Y		
TOTALS	25	14	5

Number of IE responses beginning with 'yes', 'yes well', 'well' or 'yeah' = 17
Number of IE responses <u>not</u> beginning with 'yes', 'yes well', 'well' or 'yeah' = 8
Number of IE responses <u>not</u> beginning with 'yes', 'yes well', 'well' or 'yeah' and involving insertion sequences = 1

Appendix 5 – Interviewee first responses to the interviewer's request

Interview number	Q-A	Insertion (where to begin)	Insertion (topic query)	Insertion (repetition)	Insertion (when to start)	Repetition
1	Y					
2	Y					
3					Y - 'Am I on?'	
4 No Q	-	-	-	-	-	-
5				Y		Y – IE queries
6		Y				
7	Y					
8			Y – husband's job			
9		Y				
10 No Q	-	-	-	-	-	-
11	Y					
12	Y					
13 No Q	-	-	-	-	-	-
14 No Q	-	-	-	-	-	-
15		Y				
16				Deviant case		Y – IR raises
17					Prompt to start	Y – IR raises
18				What do you mean?		
19					Is it alright like that?	
20 No Q	-	-	-	-	-	-
21 No Q	-	-	-	-	-	-
22		Y				
23	Y					
24			Y – wife			
25	Y					
26		Y – IE being specific about dates*				Y – IR raises
27	Y					
28		Y				
29	Y					Y – IR raises
30	Y					
31	Y					
Totals	11	6	2	2	3	5

Key:
Q-A - question-answer
Y - yes
No Q - interviewer's opening request is not recorded