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On clinicians co-implicating recipients' perspective in the delivery of diagnostic news

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1 Introduction

In ordinary conversation, when there is bad news to tell, it can be organized so that the recipient rather than the bearer of the news ends up pronouncing it (Schegloff 1988a).[1] By prefacing the bad news, by giving pieces of information from which inferences can be made, and so on, the bearer alludes to the tidings, and thereby induces the recipient to guess at what they are. Schegloff (1988a) provides the following telephone-call examples. In the first, Belle conveys news to Fanny about a mutual friend by announcing "something terrible":

(1) [DA:2:10]

1	B:	...I, I-I had something (.) terrible t'tell
2		you. So[u h :]
3	F:	[How t]errible[is it
4	B:	[·hhhhh
5		(.)
6	B:	Uh: ez worse it could be:.
7		(0.7)
8	F:	W'y'mean Eva?
9		(.)
10	B:	Uh uh·hh=
11	F:	=Wud she do die:?=

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talk *at* WORK

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12 B: =Mmhm,
13 (.)
14 F: When did she die,

The announcement and subsequent formulation that the news is "ez worse it could be" (line 6) are ways of clueing Fanny, who guesses at the news (lines 8, 11). Then Belle confirms these guesses (lines 10, 12). In the second example, Charlie informs Ilene, who wanted a ride, that a planned trip to Syracuse has been canceled. Referring to a third party, he starts the news delivery by citing a reason for the cancellation (lines 1, 5, 7):

(2) [Trip to Syracuse, 1-2]
1 C: She decidih tih go away this weekend.
2 I: Yeah:,
3 C: hhhh-
4 I: =kh[h
5 C: [So that:[t
6 I: [k-khhh
7 C: Yihknow I really don't have a place tuh sta:y.
8 I: ˙hh Oh:::: ˙hh
9 (0.2)
10 I: hhh So yih not g'nna go up this weeken'?
11 (0.2)
12 C: Nuh:: I don't think so.

This leads Ilene herself first to indicate a realization (line 8; see Heritage 1984b) and then to venture the bad news (line 10). Rather than announcing the trip's cancellation, Charlie now merely has to confirm Ilene's inference (line 12).

A deliverer's clues or preindications, as Schegloff (1988a: 444) points out, engage a recipient's common-sense knowledge of the world, the participants' "recipient-designed" mutual knowledge, and "their orientation to the occasion of the conversation." The practices of clueing, guessing, and confirming are also displayed in institutional settings – particularly medical ones – where professionals must convey bad news (Glaser and Strauss 1965; Sudnow 1967; McLenahan and Lofland 1976: 257). Thus, a mother recalls her experience of finding out that she has given birth to a Down's Syndrome child:

And you know he [the father] was just acting so strangely and by then you get all these apprehensive feelings which I had during the pregnancy anyhow. And then the doctor came in and he drew the curtains around my

cubicle and I thought, oh no, you know. And he told me the baby was born completely healthy, but he's not completely normal. And I looked at him and I said, he's mongoloid. And I've never seen a mongoloid baby before in my life, but all of a sudden the flat features, the thrusting of the tongue, you know, just kind of hit me in the face. And that poor doctor couldn't bring himself to say the word. He said, it shouldn't have happened to you, not to your age bracket.

(Jacobs 1969: 5)

The doctor's clues here include drawing the curtains[2] and then alluding to abnormality. Based on her "feelings" and prior, unthematized noticings, the mother guesses that the baby is "mongoloid," a matter that the doctor, by reciting how unlikely the event was, confirms in an indirect way.

These excerpts demonstrate that a bringer of bad news may have difficulty stating the news outright. By avoiding the pronouncement and simply confirming a recipient's inference, a teller can manage the conveyance as a joint activity. The bearer does not claim completely independent knowledge, and instead elicits a display of what the recipients, through their own knowledge or beliefs, can infer. In medical settings where clinicians must routinely deliver bad diagnostic news, it appears that this pattern of confirming can be actualized more explicitly than by mere reliance on clues and guesses. Clinicians can use a "perspective–display series," a device that operates in an interactionally organized manner to *co-implicate* the recipient's perspective in the presentation of diagnoses. Schematically, the series consists of three turns:

1 clinician's opinion–query, or perspective–display invitation;
2 recipient's reply or assessment;
3 clinician's report and assessment.

Because the clinician, in a manner analogous to the clueing and guessing activity described above, sets up a diagnostic telling to confirm the recipient's own perspective, a consequence of employing this series is to embed that perspective as a constituent feature of the telling.

2 The perspective–display series

The data for this chapter derive from "informing interviews" recorded in two clinics for developmental disabilities (mental retar-

dation, autism, language and learning disabilities, etc.). At such clinics, children go through an extensive evaluation process, which may include speech, psychological, psychiatric, pediatric, educational, and other kinds of examinations. When these tests are completed, clinicians meet with parents to tell them about the clinic's findings and diagnoses, and to make recommendations as to how to handle identified problems. This meeting or informing interview may last from 20 minutes to 2 hours as participants discuss a wide variety of concerns. In delivering diagnoses, clinicians may do so either immediately and *straightforwardly* (see Maynard 1989b); or they may do so *circuitously*, through the perspective–display series (Maynard 1991a). Use of this series may relate to a generic conversational strategy for giving one's own report of assessment in a cautious manner by initially soliciting another party's opinion (Maynard 1989a, 1991b).

While this chapter is mostly about turns (2) and (3) in the perspective–display series, some preliminary comments about turns (1) and (2) will be helpful in our later analyses. First, these two turns are similar to what Sacks (1992 [1966]) has called a pre-sequence. Pre-sequences include the summons–answer type, by which participants provide for coordinated entry into conversation (Schegloff 1968); pre-invitations (*Are you busy Friday night?*), by which a speaker can determine whether to solicit someone's co-participation in a social activity (Sacks 1992 [1966]), and pre-announcements (*Have you heard?*) through which a speaker can discover whether some news-to-be-told is already known by a recipient (Terasaki 1976). Depending on what a speaker finds out by initiating a pre-sequence, the conversation, invitation, or announcement may or may not ensue. Thus, in ordinary conversation, the perspective–display invitation and its reply operate like a pre-sequence and seem to have alternative trajectories. Sometimes, the asker follows a reply with his own report, or with further questions and then with his report. In this case, the third-turn report is akin to a "news announcement" (Button and Casey 1985), providing for at least some "receipt" of the report or possibly a "topicalizer" in the next turn; this topicalizer then occasions elaboration of the topic by the one who initiated the series. At other times, the reply to a perspective–display invitation will be followed by further questions or other topicalizers that permit the recipient to talk at length on

some topic. The questioner, never announcing any independent information or perspective, appears to "interview" a recipient and provide for that person to do extended topical talk. However, in the clinical environment, the relationship between the first two turns and the third-turn report in the perspective–display series appears more fixed or *rigid* than in conversation; only one of the alternative trajectories occurs. After asking parents for their view, clinicians unfailingly provide their assessment of the child (for discussion, see Maynard 1991a).

A second matter concerning turns one and two in this series: it is here that clinicians and parents may collaboratively establish an alignment regarding two matters on which the delivery of diagnostic news depends: the existence of a child's problem and the expertise of the clinic for dealing with it. Turn 1, the perspective–display invitation, elicits the parents' view of their child, and does so through a variety of forms. A major distinction is between those queries that are *unmarked* and those that are *marked*, depending on whether they initiate reference to a problem as a possession of the queried-about child. When an invitation itself proposes a problem or difficulty, it is marked:

(3) [8.013]

Dr:	What do you see? as- as his difficulty.
	(1.2)
Mo:	Mainly his uhm: (1.2) the fact that he doesn't understand everything (0.6) and also the fact that his speech. (0.7) is very hard to understand what he's saying.

When an invitation does not propose a problem in this way, it is unmarked:

(4) [9.001]

Dr:	Now that you've- we've been through all this I just wanted to know from you:::. (0.4) ˙hh how you see Judy at this time
	(2.2)
Mo:	The same.
	(0.7)
Dr:	Which is?
	(0.5)
Mo:	Uhm she can't talk . . .

Marked queries presumptively ask parents for their view and occasion, from the parents, an immediate account of the child's difficulty. Unmarked queries are less presumptive but nonetheless also seek an eventual formulation of a child's problem. Once clinicians and parents exhibit accord on the existence of a problem, this also implies an alignment as lay and professional participants with regard to expertise for understanding the problem's exact nature. The very proposing of a "problem," that is, reflexively suggests a course of action in which parents, in one way or another, have sought out the clinic for its specialized knowledge. Establishing these matters sets up a hospitable environment that allows clinicians to present the diagnosis relatively smoothly. Nevertheless, in reply to a perspective–display invitation, a parent may resist a problem formulation. This, as we shall see, necessitates a specific kind of interactive work before the clinician can deliver the diagnostic news.

After parents display their views, then, clinicians regularly deliver diagnostic news as a *confirmation* of what has been said. Depending upon the relation of the elicited perspective to the clinical position, such confirmation can be relatively simple or more complex. If the parents formulate some problematic condition that is perceivedly close to the clinical position, then the confirmation will be accompanied only by a reformulation and technical elaboration of the parent's version. When the clinical diagnosis departs significantly from that version, a diagnostic presentation will be accompanied by work that, while still confirming and reformulating what parents have said, also "upgrades" the severity of a child's condition. Overall, it is the possibility of confirming the parent's view that seems central to the diagnostic news delivery done through a perspective–display series. Furthermore, this confirmation is an *achieved* phenomenon. When parents go along with, or themselves produce, problem proposals, the nature of this achievement is somewhat hidden. But when parents are resistant to problem proposals, we can clearly see that the alignment between clinician and parent is a matter of delicate interactional management.

To demonstrate these matters, I will begin by showing how "simple" confirmations work, and how they are achieved features of using a perspective–display series. Then I will take up progress-

ively more "complex" deliveries that involve "upgrading" the nature of a condition to which parents have alluded. With more complex diagnostic news deliveries, every step in the process of leading towards a diagnosis can involve or invoke the parent's view, such that when some ultimate diagnostic term is produced, it appears as something on which clinician and parent, in a variety of ways, converge. This convergence may include, in addition to their displayed, mutually reinforcing *views*, demonstrations of the parties' shared *reactions* to the condition. In the end, however, convergence and mutuality come to be based on the clinical position, not the parents' version or one that is in between. While clinicians may demonstrate agreement with, and/or understanding of the parents' perspective, a claim is mounted that the parents' view affirms the very diagnosis of which they are now being informed.

3 Diagnostic news as confirmation

Simple confirmations occur when a clinician displays agreement and offers to reformulate and elaborate the parent's displayed view along more technical lines:

delivery of diagnosis = confirmation + reformulation
+ elaboration

The next excerpt shows the pattern; it begins with a perspective-display invitation (line 1) and a reply (lines 3–7):

(5) [8.013]

1	Dr:	What do you see? as- as his (0.5) difficulty.
2		(1.2)
3	Mo:	Mainly his uhm: (1.2) the fact that he
4		doesn't understand everything. (0.6) and
5		also the fact that his speech (0.7) is very
6		hard to understand what he's saying (0.3)
7		lot [s of ti]me
8	Dr:	[right]
9		(0.2)
10	Dr:	Do you have any ideas wh:y it is? are you:
11		d[o yo]u? h
12	Mo:	[No]
13		(2.1)

14	Dr:	˙h okay I (0.2) you know I think we basically
15		(.) in some ways agree with you: (0.6) ˙hh
16		insofar as we think that (0.3) Dan's main
17		problem (0.4) ˙h you know does: involve you
18		know language.
19		(0.4)
20	Mo:	Mm hmm
21		(0.3)
22	Dr:	you know both (0.2) you know his- (0.4) being
23		able to understand you know what is said to
24		him (0.4) ˙h and also certainly also to be
25		able to express:: (1.3) you know his uh his
26		thoughts
27		(1.1)
28	Dr:.	˙hh uh:m (0.6) ˙hhh in general his
29		development . . .

In her reply, the mother (Mrs. C) formulates her son's problem, after which the clinician (Dr. E) produces an agreement token (line 8). This token may encourage continuation on the part of Mrs. C, which does not occur (silence at line 9). Next, Dr. E initiates a question–answer sequence concerning "why" there is a problem (lines 10–11), which is unsuccessful in eliciting further material from his recipient. Then, although qualifying himself, Dr. E more fully expresses agreement with Mrs. C's perspective (lines 14–15), and reformulates the parent's complaint about Dan's understanding and speech as involving a "main problem" the child has with "language" (lines 16–18). Dr. E also precedes the reformulation with emphasis on the verb "does," which is a way of tying to the parent's prior assessment and further marking agreement with it.[3] Following Mrs. C's continuer (line 20), Dr. E elaborates on the diagnosis (lines 22–6), incorporating one term ("understand") that repeats what Mrs. C has said (line 4) and also using another ("express his thoughts") that is hearably a close version of Mrs. C's reference to "speech" (lines 5–7). In this series, the clinician's activities of confirmation, reformulation, and elaboration are all present and they severally work to co-implicate the parent's perspective in the diagnostic news.

Not any or all parental replies to a perspective–display invitation will offer an auspicious context for a confirming diagnostic news delivery. For instance, in replying to a perspective–display invitation, parents may take a position that there is no problem.

Clinicians with "bad" diagnostic news to deliver are not, then, in a position of being able to confirm. Instead, they may have to work to *achieve* just that conversational environment which is ripe for a confirmatory delivery. Clinicians have a variety of devices for handling the "no problem" reply from parents, such as listening for or encouraging talk in which some diagnosable condition or difficulty is eventually broached (Maynard 1991a).

(6) [47.001] (Simplified)

1	Dr:	How's Bobby doing.
2	Mo:	Well he's doing uh pretty good you know
3		especially in the school. I explained the
4		teacher what you told me that he might be
5		sent into a special class maybe, that I was
6		not sure. And <u>he</u> says you know I asks his
7		opinion, an' he says that he was doing
8		pretty good in the school, that he was
9		responding you know in uhm everything that
10		he tells them. Now he thinks that he's not
11		gonna need to be sent to another school.
12	Dr:	He doesn't think that he's gonna need to be
13		sent
14	Mo:	Yeah that he was catching on a little bit uh
15		more you know like I said I- I- I <u>know</u> that
16		he needs a- you know I was 'splaining to her
17		that I'm you know that I know for sure that
18		he needs some special class or something.
19	Dr:	Wu' whatta you think his <u>pro</u>blem is.
20	Mo:	Speech.
21	Dr:	Yeah. yeah his main problem is a- you know a
22		language problem.
23	Mo:	Yeah language.

This excerpt starts with an unmarked invitation, which initially obtains a positive assessment from the mother, Mrs. M (lines 2–3). However, in the course of reporting a conversation with her son's teacher (lines 3–11, 14–18), Mrs M exhibits a position implying that she sees Bobby as having a problem ("I know for sure that he needs some special class or something," lines 17–18). Dr. E immediately follows this with a marked invitation (line 19) or one that contains a problem proposal. With this, he takes up what Mrs. M had implied and asks her for an explicit problem formulation, which she provides at line 20.[4] Then Dr. E uses two "yeah" tokens

to confirm her perspective, and yet reformulates what she has said by suggesting that the "main problem is ... a language problem" (lines 21–2).

Also note how the parent receives the diagnosis by changing her terminology to match the clinician's (line 23).[5] Subsequently (in talk not reproduced here), Dr. E elaborates the diagnosis using words that further incorporate Mrs. M's displayed perspective. Overall, then, the way in which the parent's perspective is co-implicated in the delivery of diagnostic news here is similar to the previous example, with the exception that the clinician must strategically deal with an initial positive assessment on the part of recipient. Thus, the confirmation type of delivery is an achievement in that it depends on parents presenting not just anything in reply to a perspective–display invitation, but just that material which allows agreement and confirmation to be done. When that material is not initially produced, clinicians will seek it out, which suggests that their use of the perspective–display series is oriented to developing a hospitable environment for delivering a diagnosis.

4 Upgrading a condition

Even when a clinical diagnosis departs significantly from a recipient's position, the delivery still can involve a confirmation. Once that confirmation is performed, clinicians may reformulate and then add the upgraded diagnosis onto what has already been said. It seems, then, that "complex" deliveries have a progressivity to them that is set off by confirming the parents' view:

delivery of diagnosis = confirmation + reformulation + upgraded diagnosis + elaboration

What distinguishes the upgraded diagnosis from reformulations or elaborations is evidence internal to the talk between clinician and parent showing that both may be oriented not just to a difference in vocabulary but to a difference in level of seriousness. That is, the distinction between lay and professional terminology in earlier examples appeared to be a technical one. However, in contrast to lay terminology, professional nomenclature can imply a more critical and potentially stigmatizing condition for a child. In this situ-

ation, parents may subtly resist a proffered diagnosis, and clinicians will show a sensitivity to this resistance.

For instance, in one interview, a clinician asked a mother how she felt about her daughter's "functioning in the school." The mother replied that the girl was "not right on her level that she should be," that the teachers "don't think she's on her level," and that "she is kinda slow":

(7) [3.047]

1	Mo:	. . . and I have seen no progress, from
2		September to June. For her learning
3		ability, she is slow.
4		(0.6)
5	Dr:	That's what we uh:: also found on- on
6		psychological testing. ˙hhhh That she was
7		per- <u>not</u> performing like a normal (0.2) uh:::
8		six and a half year old uh (0.4) should.
9	Mo:	mm hmm
10	Dr:	And that she was performing more uh (0.3)
11		˙hhhh what we call as a borderline (0.4)
12		rate of retardation ˙hhh uh:::m
13		(2.2)
14	Dr:	For a <u>no</u>rmal (0.4) kind of might use a
15		number ˙hhhh it's usually about hundred
16		(0.2) or more. (0.6) and anywhere between
17		uh:: (0.3) eighty <u>two</u> and (1.2) uh:::: (0.4)
18		ninety is kind of uh:: (0.4) borderline
19		(0.6) kind of uh:: (0.2) ˙hhh functioning.

Here, the clinician, Dr. H, employs another device for confirming the parent's perspective, suggesting (line 5) that the clinic has "also found" what the mother has just said about the child being slow. Then, the clinician proposes to reformulate this as "<u>not</u> performing like a normal . . . six and a half year old" (lines 7 and 8). This reformulation is met with a continuer at line 9, following which, Dr. H, by way of the "and" (line 10) adds a clinical term, "borderline rate of retardation" (lines 11–12). Note, then, that reformulations may foreshadow the upgraded diagnoses they precede. After this, at line 13, there is a large silence. In systematic fashion (see Pomerantz 1984a; Sacks 1987), this at least shows, on the part of the parent, an unwillingness to endorse the clinic's terminology and can indicate a withheld disagreement (Maynard 1989b). Sub-

sequently, while Dr. H appears to explain the diagnosis (lines 14–18), in returning to the diagnostic category, he no longer refers to "retardation," and instead pairs "borderline" with "kind of functioning" (lines 18–19). Thus, Dr. H *retreats* from using a term that was added on to a confirmation and reformulation of the parents' version, which indicates the clinician's understanding that it may not have been as acceptable as the previous reformulation. Indeed, just after line 19 above (in talk not reproduced here), Mrs. B says, "Well I think she will progress later," and suggests that the child will do better in second grade. Then, Dr. H shows a further orientation to the difference in positions, stating, "One of the reasons why we are having this conference is also to make you aware of her limitations, and not to agree with you in everything that you say, saying that she is going to catch up, and she is going to do well in second grade or third grade and such things like that."[6]

Another interview illustrates this same feature of a clinician retreating from the presentation of an upgraded diagnosis when the parents, Mr. and Mrs. H, show a lack of receptivity. In lines 1–5 below, the father is replying to a perspective–display invitation (see Maynard 1989b for a fuller account). Following this reply, the clinician, Dr. R, delivers a confirmatory report (lines 7–10). While Dr. R here reformulates "maturing" (line 4) as "development," he reproduces the father's term "stopped" and marks agreement with this term by stressing the word "has."

(8) [17.050]

1	Fa:	You know I think basically the problem is as
2		I also said to Ellen that uh when you reach
3		the age of about four or four and a half
4		(0.9) you more or less stop maturing right
5		there.
6		(0.4)
7	Dr:	Yeah (1.6) Well that kind of leads into what
8		we found uh (0.2) ˙hh essentially what we
9		have <u>found</u> in Robert is that (0.4) at (0.4)
10		a certain point his development <u>has</u> stopped.
11		(0.2)
12	Fa:	Right
13		(0.2)
14	Dr:	A::nd uh::: (0.2) when tested (0.4) he then
15		tends to look to us: like a kid with
16		retarded development.

17 Mo: Mm h[mm
18 Fa: [Mm]::=
19 Dr: =This is a kid who's reached a certain point
20 and then he stopped.
21 Fa: Right.

Following this confirmatory report, Mr. H produces an agreeing continuer (line 12), which, in turn, sets the stage for an additional, upgraded diagnosis (lines 14–16). But after the official term, "retarded development," is presented, the parents both produce neutral continuers (lines 17–18). Then, Dr. R retreats to the prior terminology of the child's development as "stopped" (lines 19–20). This utterance is followed by another agreement token (line 21) from Mr. H. In part, it is the contrast between agreement tokens in the environment of terms such as "stopped development" and neutral continuers in the context of "retarded development" that indicates a resistance to which the clinician seems responsive. And, as in the interview from which excerpt (8) is taken, there is later evidence in this interview that the parents disagree with the "retarded" term. At one point, after the parents had been extolling Robert's skills at school, a social worker who was present in the interview asked the parents, "So you don't think he's retarded?" Mrs. H replied, "No," and Mr. H answered, "No I wouldn't say he's retarded at all." It therefore seems clear that the neutral continuers in excerpt (8) are withholding a display of such disagreement in this particular environment of diagnostic news delivery. While at this point the clinician presumably does not fully know of the parents' opposition to the term "retarded," he nevertheless demonstrably orients to the "minimalness" of their responses. (See the discussion in Maynard 1989b.)

Examples (7) and (8) show how asking the parents for their view may obtain a problem formulation that indicates a relatively hospitable environment for a confirming type of diagnostic news delivery. However, while being able to confirm and reformulate a parent's view may go smoothly, adding an upgraded diagnosis may not result in felicitous treatment by parents. Anticipating this, clinicians may employ other devices that help prepare the way for an upgraded diagnosis. The result can be long and complex deliveries of diagnostic news. I will examine a complex delivery, which shows that, through the perspective–display series and related devices, it is

possible to reduce very stark disparities between parental and clinical perspectives regarding the condition of a child.

5 Reducing disparity

If we were to categorize or code the parental and clinical perspectives in the interview from which the next excerpts (9a–f) derive,[7] these perspectives would appear far apart, if not contradictory. Objectively, in fact, the situation would seem to present a high probability of argument and conflict:

Summary codification – Example 9

Parent's perspective	*Clinician's perspective*
the basic condition is hyperactivity	hyperactivity is one condition among several
the problem is temporary	the problems are not temporary
there is no brain damage	there is brain damage, which is the basic condition

We might predict that clinician and parent would dispute the child's symptoms, the duration of his condition, and what the basic condition is. Instead, as the interview proceeds, the distance between the participants narrows and the clinician's informing occurs harmoniously and affirmatively rather than argumentatively or conflictually. In part, this may be because, after confirming and reformulating the parent's perspective, but before moving to present an upgraded diagnosis, the clinician engages in *converting* and *identifying*, which are two other forms of co-implicating the parent's perspective. These forms, along with the perspective–display series and its progressive manner of presenting diagnostic news, help reduce the disparity between parties' perspectives. However, they do not imply compromise between the parties, nor do they involve negotiation over the existence, nature, and duration of problems. By proposing to bring a recipient's perspective in line with the clinical position, these forms are persuasive devices.

The first excerpt from this interview starts with the parent, Mrs. L, attributing to the clinician a particular statement regarding the potential of her son (lines 1–3 below). When, at line 4, Dr. C seems

to disaffiliate from this attribution, Mrs. L backs down (line 5). And after Dr. C completes her utterance at line 6, the parent acknowledges Dr. C's position (line 7). Then, the clinician probes (lines 8–9) Mrs. L for her own view on the matter of her son's potential, which she gives in lines 10–11:

(9a) [30.001] (simplified) (The mother, Mo, is referred to in the text as "Mrs L")

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1   Mo:   ... from what I was told in the beginning
2         and you told me too, he will outgrow this as
3         he goes along.
4   Dr:   Well. Yeah. It's not exactly-
5   Mo:   more or les[s  h : : : ˙hhhh  ]
6   Dr:              [important what I] said.
7   Mo:   Yea[:h ]
8   Dr:      [Wh] at- what do you think, I mean do you
9         think Barry will outgrow his problems?
10  Mo:   Well! I think so, in way- I hope so! in
11        ways. Because you know...
```

In a qualified way, then, Mrs. L indicates a belief that her son will outgrow his problems (lines 1–3, 5, 10–11), and goes on (in talk not reproduced here) to list several reasons why: he will get proper preschooling, eventually go into a regular school, take medication, and she had been told that his problems were childhood ones that would only last until puberty.

After this, the clinician introduces a typical perspective–display invitation:

(9b) [30.016]

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Dr:   What do you think is wrong with him.
      (0.3)
Mo:   Well:, he's hyperactive child.
Dr:   Mm [hmm  ]
Mo:      [˙hhhh] so:::, the definition they said
      when a baby's born the brain is developed,
      to that certain point. ˙hhhhh now with
      hyperactive child, that brai- the brain
      hasn't developed, to that certain point...
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From here, Mrs. L goes on to explain her concept of hyperactivity, and in reply to a question from the clinician, indicates hearing the explanation and diagnosis from a cousin who had seen a pediatric neurologist and psychiatrist because her child seemingly had similar

problems. Mrs. L's alluding to this seems to warrant an inference from Dr. C, which, however, is disconfirmed:

(9c) [30.070]

Dr:	So . . . you suspect there's something wrong with Barry's brain then?
Mo:	We:ll::, um (.) uh:::m, not really, I would say (.) learn::ing (.) difficulties. You know, like uh he wasn't grasping.

Mrs. L next describes when problematic behavior first started (at age two) and how she became more suspicious that something was wrong when B was age three because he still was not "talking right" and was resistant to toilet training.

Then, through various displays of agreement, Dr. C confirms Mrs. L's views. Below, at line 5, the clinician uses a formulaic expression ("we agree with you"), although she also qualifies it (lines 6–7). In addition, at line 9, redoing an utterance that was overlapped by Mrs. L's line 8 query, Dr. C emphasizes or accents the verb "is" before repeating the very term ("hyperactive") that Mrs. L has used. At line 11, the clinician also stresses the verb ("has") which prefaces a gloss ("trouble") of what the parent discussed earlier. As mentioned, such emphasis is a way of both tying to the prior talk and marking agreement with it.

(9d) [30.119]

1	Mo:	[(So that's) how I th ought something was
2	Dr:	[So that's why we-]
3	Mo:	wro [ng th ere.
4	Dr:	[right]
5	Dr:	And (0.3) you know, we (.) we agree with
6		you, you know, we- ih- cer- to the certain
7		degree. [W e f e e l t h a t]
8	Mo:	[Is he gonna be all] right. heh huh
9	Dr:	We- we feel that (0.3) Billy is: hyperactive.
10	Mo:	Yeah.=
11	Dr:	=y'know:, and he has had trouble, (.) for a
12		long ti:me. [˙hhhh]
13	Mo:	[Yeah.]
14	Dr:	But we don't see this as something that's
15		just gonna pass:
16	Mo:	Y [eah, well I know that,]
17	Dr:	[and an- go away.]
18	Mo:	Right.

Subsequently, at lines 14–15, Dr. C, using a contrast marker ("but") and contrast stress on the verb "don't" (see note 3), takes up a position that contradicts what the parent has said regarding the child outgrowing his problems, and thus reformulates Mrs. L's version of the problem. Technically, while this is a *disagreement* (Pomerantz 1984a; Sacks 1987), it follows the preference form in which it is packaged as *agreement*. That is, the disagreement is postpositioned within the turn it occupies by the occurrence of preceding agreements and the contrast marker.

In a sense, the confirmation and reformulation succeed here. That is, after Dr. C produces various terms and characterizations, Mrs. L gives indications of assent (lines 10, 13, 16) and seemingly aligns (at line 18) with the proposed reformulation (lines 14–15, 17) thereby apparently relinquishing her earlier-stated view regarding the temporariness of the problem (see example [9a] above), and also possibly defusing a potential argument.[8] So far, this excerpt is similar to examples (5) and (6) above, wherein the clinician confirms and then suggests a reformulation of what a parent has said. And here, as in (6), the parent clearly accepts the suggestion.

In this instance, however, the confirmation-reformulation is not the end of the line or the immediate prelude to an elaboration; it precedes a move to present more serious diagnostic terminology. Moreover, in contrast to examples (7) and (8), this move involves other work on the part of the clinician, who proposes *converting* the parent's formulation of the problem to being among items on a list of things. Below (lines 4–5), Dr. C suggests that hyperactivity is "one of the problems" that B has, and then proffers "another" difficulty of the child and details its characteristics (lines 7–8, 10–11, and 13–14).

(9e) [30.134]

1	Dr:	He ha:s serious problems.
2	Mo:	Hm::
3	Dr:	A:nd, you know, we don't know:: what kind of
4		term to apply ta these problems. One of the
5		problems is that he is hyperactive. h [˙h h h h
6	Mo:	[Mm hmm]
7	Dr:	another is that he's just sort of
8		disorganized, in the way he [takes] in the
9	Mo:	[(Mya)]
10	Dr:	world, he doesn't take it in the way ˙hh

11 other children,
12 Mo: Y[eah.]
13 Dr: [his-] his age. ˙hhh He can't put things
14 together in his mi::nd the wa[y othe]r
15 Mo: [Ye::ah]
16 Dr: children would.

Mrs. L, in providing continuers (lines 6, 9, 12, 15) that allow the production of these detailings, at least "goes along with" Dr. C's descriptions and, insofar as "yeah" (lines 12, 15) is stronger than "mm hmm" in this regard, may even agree with them.

The activity of converting, in short, involves the parent assenting to the assemblage of a list that incorporates her version of the basic problem as apparently equivalent to other members of that list. It is no longer that hyperactivity is the son's basic problem, as was the parent's initial perspective. Now, that is one item in an inventory, which also includes being "disorganized" in taking in the world, and having difficulty putting "things together in his mind." Such conversion figures in the Dr. C's delivery of the core diagnosis, which comes after the two participants go on to discuss how Billy is doing in the "readiness program" at school. Dr. C, upon stating that Billy will "progress and learn, but he will always have a definite problem," reintroduces the issue of something being "wrong with the brain" (lines 1–4 below; cf. [9c] above):

(9f) 30.186
1 Dr: Now when you say: uh you know, the ter:m
2 something wrong with the brain, is very
3 vague, we don't like it (.) you
4 don[’t like it.]
5 Mo: [Yeah right.]
6 Dr: But ˙hhhhh when we have to descri:be Barry's
7 problems, we would have to say that there is
8 something, that [is not] working right
9 Mo: [Yeah]
10 Dr: in the brain
11 Mo: Mm
12 Dr: that's causing these things. It's causing
13 the hyperactivity, ˙hhhh [it's:] causing him
14 Mo: [Yeah]
15 Dr: ta see the wor::ld, in a different way, from
16 other children,
17 Mo: Mm yeah
18 Dr: It's causing him to be:- his (.) thoughts to

19   be maybe a little disorganized, when he
20   tries ta <u>or</u>der the world,
21 Mo: Mm::
22 Dr: in his mind. And ˙hhhh if you know, we had
23   ta say, uh if we had ta give a diag<u>no</u>sis
24   (0.2) ˙hh you know when you write away to
25   schools:: or ta other doctors, you have to
26   write something down as a diagnosis. I feel
27   that hyperactivity, just alone, wouldn't be
28   enough.
29   (0.2)
30 Mo: Mm [hmm]
31 Dr: [˙hhh] and that we would <u>ha</u>ve ta say
32   <u>so</u>mething like brain damage.
33 Mo: Mm hmm
34 Dr: in terms of (0.2) of Barry's problems
35 Mo: Mmm.
36 Dr: Because it's a kind of thing that's- it's
37   <u>not</u> jus:t hyperactivity that's gonna be
38   helped with a little medicine. ˙hhhh He- he
39   is going to nee:d, (0.5) a s- special
40   education: (.) all the way through.
41 Mo: Uh ha.
42 Dr: We feel.
43 Mo: Yeah.

The beginning of this excerpt shows the phenomenon of *identifying*. As evident in numerous interviews, this involves procedures whereby a clinician construes the parents' feelings in regard to hearing projected diagnostic terminology. Here, there are two aspects to the proposed identifying. Firstly, at lines 2–4, Dr. C acknowledges that her own reference to "something wrong with the brain" is "very vague," claims not liking the phrase, and suggests that this attitude is shared by her recipient, who agrees (line 5). Thus, if it is agreed that "we" and "you" do not like something, it exhibits a mutuality in one attitudinal area for the otherwise-partitioned sets of people who are so categorized.

Secondly, in moving to the diagnostic presentation, Dr. C portrays herself as forced to do so. She invokes the phrase "have to" in reference to (a) describing "B's problems" (line 6) and (b) saying the brain is not "working right" (lines 8, 10). Recall that Mrs. L has already shown resistance to characterizations of the severity and nature of the child's problem (she thought the problem would eventually go away, and that it was not brain damage). Being

forced to describe problems and to say the brain is not working right, while not disavowing such matters, at least mildly mimics Mrs. L's resistance to these characterizations. In summary, identifying with a recipient in these ways takes her perspective into account by intimating that the clinician can understand what it is like to confront the bad news that must be delivered. This is a slightly different way of co-implicating the parents' perspective than we have seen so far, for it means that the clinician has incorporated already-displayed and yet anticipated reactions to the diagnosis.

The co-implicating of a parent's perspective is also accomplished here in the more usual sense, when Dr. C reinvokes the converting and detailing from excerpt (9e), which include Mrs. L's view regarding the nature of the problem. At lines 8, 10, and 12, that is, Dr. C suggests that the brain problem may be "causing these things" (line 12), a phrase that ties to the previously named symptoms (hyperactivity, seeing the world in a different way, having disorganized thoughts) that are reassembled within a three-part list (lines 12–13, 15–16, and 18–20), a rhetorical device that implies a sense of coherence, completeness, and unity (Atkinson 1984:57; cf. Jefferson 1990) to the package of symptoms. Beyond the sheer content of the list, Dr. C thereby appeals for some other condition to be "causing" them. And each part of the list meets with continuers, including two agreement tokens (lines 14 and 17) that permit Dr. C to progress to delivery of the official diagnosis. Thus, as opposed to being some unilateral declaration of Dr. C, the listing is collaboratively produced. Accordingly, to the extent that this listing serves as a warrant for the upcoming diagnosis, the basis for the warrant is in the parent's as well as the clinic's perspective.

Finally, in arriving at the actual term, Dr. C again portrays herself as forced to give it (lines 22–6), and invokes the institutional context – having to "write away" to schools and doctors – as an explanation for such force. The theme of partial resistance is thereby once more salient, and serves as a prelude to Dr. C discounting the parent's term, "hyperactivity" (lines 26–8), before going on to pronounce the diagnosis of brain damage (lines 31–2). This diagnosis, in a variety of ways, is an "upshot" (Heritage and Watson 1979) of what has gone before, and, as Dr. C elaborates (lines 36–40), also projects a specific, recommended treatment (special education as opposed to medication). The proposal for treatment here illustrates how closely therapies are linked to diag-

nostic terms and may be driving their use. That is, the very careful movement away from the parents' perspective and towards the clinic's position reflects not just an abstract concern with correct terminology, but with concrete remedies for the problems (Teas 1989).[9]

In review, this informing interview begins with a query and a perspective–display invitation that succeed in eliciting the parent's view of her child's condition as being temporary and basically involving hyperactivity. The third part of the perspective–display series follows a format in which the clinician confirms, reformulates, and then upgrades the conditions that the parent has named. The confirmation entails the clinician agreeing with the parent's proposal of hyperactivity, while the reformulation contradicts what the parent has said regarding the temporariness of the problem. After the parent gives signs of changing her perspective on this issue, the clinician proposes additional problems to the hyperactivity, *converting* the latter to one among several symptoms. The parent also goes along with these proposals, and then the clinician delivers a term that is "upgraded" with respect to another aspect of the parent's perspective. Whereas Mrs. L had resisted the suggestion that something was "wrong with B's brain" (example 9c above), the clinician subsequently (9f) presents "brain damage" as the basic diagnosis. Dr. C prefaces this delivery by *identifying* with the parent and by invoking the agreed-upon symptomology.[10] Although the interview would objectively exhibit disparities between parent and clinician, the perspective–display series and related strategies of co-implicating parental perspectives in the delivery of diagnostic news permit positional differences between the deliverer and recipient to be publicly overcome.[11] The movement that overcomes such differences is in the direction of the clinical position, and thus the series may be a persuasive way that clinicians ratify and confirm a parent's own perspective even while suggesting, indeed using that perspective to affirm, the alternative.[12]

6 Conclusion

The perspective–display series is a means by which participants to a clinical informing engage a circuit of talk that displays recipient's view as a prelude to the delivery of diagnostic news. By way of this series, clinicians can deliver, as a product of talk and interaction, a

diagnosis that confirms and co-implicates recipient's perspective. In initiating the series, a perspective–display invitation seeks material from parents with which agreement can be formulated, to thereby begin, with a confirmation of what the parents had to say, a progressive delivery of diagnostic news. Upon this confirmation, clinicians can build reformulations, upgraded diagnoses, and technical elaborations. As compared with the clueing, guessing, and confirming strategy identified at the outset of this chapter, the perspective-display series more explicitly engages the recipient's perspective for a bad news delivery, yet still has this confirmatory aspect as a central feature.

Devices such as identifying with the recipient and converting the recipient's formulation of the problem to a symptom of something more basic may be employed in service of a progressive news delivery. In all, these mechanisms allow for diagnostic presentations that contain a parent's perspective as an embedded feature, and may thus persuade a parent to align with the clinical position. A further effect of using the perspective–display series is to portray the clinician not as one whose assessment is an independent discovery, nor the parent as one who must be moved from a state of ignorance to knowledge. Rather, the parent is one who partially knows the truth and the clinician is one who, in modifying or adding to what a parent already knows or believes, proposes to ratify the displayed perspective.

We can highlight these matters by comparing this sequence and circuitous news deliveries to those that are more direct or straightforward (e.g. Heath this volume; Maynard 1989b). First, straightforward deliveries may be preceded by other devices that propose to co-implicate the parents' perspective. For example, in one instance, a clinician led up to a relatively blunt delivery of a mental-retardation diagnosis by congratulating the parents on the "extraordinary job" they had done with their son. As herself the mother of a physically disabled child, the clinician also engaged in identifying, remarking "You know Mrs. R [the mother] and I can talk as parents as well as my being a professional."[13] However, while such prefacing mechanisms may show the clinician's appreciation of the parents' situation, they do not draw out the parents' beliefs or knowledge in the way that the perspective–display series does.

Second, when a clinician presents a diagnosis directly and detects

resistance from the parents, it is possible to handle the difficulty through a retrospective elicitation of their perspective (Teas 1989).[14] In the next excerpt, Dr. V's mention of "going through all this" (lines 1–2) refers to the findings from separate diagnostic examinations that other clinicians in the room have reported.

(10) (I:39:17)

```
1   Dr:   ˙hh you know again ˙hh a::hm (.) the reason
2         for going through all this ah- obviously
3         when you have a kid who's way behind you
4         worry about mental retardation.
5         (0.4)
6   Dr:   That's what we're y'know (.) discussing that
7         issue. ˙hh A:hm ˙h
8         (2.0)
9   Dr:   you do:n't- and when y'talk about me:ntal
10        retardation what (.) we usually mean is
11        something y'know y- what parents are always
12        saying y'know ih- is the permanence of this.
13        Okay I know he's behind. ˙hh Fact you've
14        done a better job (1.0) ˙hhh we didn't even
15        need to do our testing. ah Lyn reminded me
16        ah (.) that (.) horrendous form that you filled
17        out. (0.6) You kno(h)w that- whatever it was
18        two three hundred item ah- can he do this
19        can 'e do this can 'e do that, you're ˙hhhh
20        getting the same numbers as we are.
21        (1.5)
22  Dr:   A:h when you score the stuff that you guys
23        [d i d ]
24  Mo:   [Right ]I was wonderin bout that.=
25  Lyn:  =Yeah there was an iden [tical profile   ]
26  Mo:                           [You know that   ]three
27        hundred twenty question, [I did
28  ( ):                           [((laughter))
29  Do:   And so- yeah. And when you score all that
30        ahm (.) y' yer yer what chu in effect said
31        was that in most areas of development (.)
32        he's looking like ah somewhere between two
33        ta three years. (0.5) In skills. (0.4) More
34        like what you've said that you feel yer
35        (1.5) yer three year old is (1.0) y'know
36        doing bout the same. . . . So wha chu've
37        generally done the first thing is that uh-
38        this evaluation has been a ti:me consuming
```

39 an an expensive confirmation (1.5) of what
40 you've been seeing, that he's functioning
41 between a two and three year level on most
42 things. That's what you've been hearing=
43 Mo: Mm hmm

At line 3, when Dr. V broaches the diagnosis, mental retardation it is as a possible upshot of the reported findings. Both parents are present at this interview, and their postures are rigid, their faces impassive, as the term is mentioned. Then, at two points of transition relevance (lines 5 and 8), neither one elects to talk.[15] Following this, Dr. V begins to elaborate the term (lines 9–13), and quotes the parents as acknowledging that their child is "behind," which seems to "touch off" a series of utterances in which he compliments the parents (lines 13–17) for filling out a long form that he then suggests shows them getting the "same numbers" (lines 19–20) as the clinicians. Lyn, a special-education consultant on the case, agrees and further proposes that the parents' assessment is "an identical profile" (line 25). After reciting some specifics of the assessment, Dr. V characterizes "this evaluation" – the clinic's – as "an expensive confirmation of what you've been seeing" (line 39–40).

Thus, it is possible for a clinician to adduce a recipient's perspective in other ways than through asking for it, after the delivery rather than before it, and as a means of handling or repairing interactional difficulties, such as the impassiveness and silences of the parents in (10), which emerge at the point of this delivery. Then, "confirmation" occurs under the auspices of recovering from a diagnostic presentation rather than under those of anticipating it. As an overall matter, therefore, the delivery of diagnostic news, like the bearing of bad news generally, may be organized in a variety of ways to embed recipient's perspective as a constituent feature of the presentation. By comparison with other means of delivery, however, use of the perspective–display series accomplishes the co-implication of recipient's perspective in a strong fashion. Rather than contingently responding to emergent displays of resistance or emotion, and rather than simply appreciating the difficult situation of recipients, clinicians can preliminarily elicit their *view* of the situation. And no matter what the disparity between recipient and clinical perspectives, or how serious the condition, clinicians can

work through the series in a way that proposes to confirm what recipients already know and believe, even while using the latter to affirm the diagnostic presentation itself.

The perspective–display series is not characteristic of clinical talk alone. Just as the clueing–guessing–confirming mechanism for telling bad news occurs in ordinary conversation and in clinical environments, so too does the perspective–display series appear in both contexts. In conversation, initiating the series is an inherently cautious maneuver that contrasts with the outright offering of a report or assessment (Maynard 1989a). For example, by way of this series, unacquainted parties who do not have prior knowledge of each other's attitudes can see whether and how one's report or assessment can fit with the other's views of some social object. Similarly, well-acquainted parties can employ the series when their circumstances warrant caution. That is, where persons have a previously unarticulated concern or opinion to express, and are not sure how well a friend or relative will understand or receive it, they can first "test the waters" for the degree of hospitality which the expression might meet. If the circumstances allow, then persons can deliver their report, assessment, or opinion in a confirmatory way. Among both unacquainted and acquainted parties, producing potentially controversial displays of perspective in this way shows the interactants' orientation to a kind of social solidarity in their relationships. It seems, then, that the perspective–display series is a conversational mechanism that is *adapted* to a clinical environment where professionals must inform parents or patients of highly charged diagnoses (Maynard 1991b). By co-implicating their recipients' knowledge or beliefs (and anticipated reactions) in the news they have to deliver, clinicians present assessments in a publicly affirmative and nonconflicting manner. In short, the series represents a solution to interactive problems that transcend the clinician–parent or doctor–patient relationship. At least in some ways, rather than being a unique species of interaction, talk in institutional settings is continuous with that in ordinary life.

Notes

1. This is a paraphrase of Schegloff (1988a: 443), who states: "Conveying information to another and telling that person something may be

quite different matters. It was my colleague Harvey Sacks I think who first pointed out that when it comes to bad news, the talk can be organized in such a manner that the recipient of the news can turn out to be the one who actually says it." See also Terasaki (1976: 28–9) and Drew (1984: 133–6).

2. Privatizing the encounter between physician and patient can, of course, mean many things, but in a context of ambiguity surrounding major events such as birth, accident, illness, and death, it seems particularly indicative that some bad news is to come. See, for example, Sudnow (1967: 126, 129).
3. Sacks (1992 [1967]: 12) discusses the use of accent or emphasis with respect to possessive pronouns such as "my," "mine," "our," "ours," etc. If any given utterance contains such accent, "that is a pretty sufficient signal that the utterance is tied, and tied via a contrast of that possessive pronoun (or the speaker of it) and some other: 'Let's take my car.' 'No, let's take MY car.' " With verbs, the pattern seems to be that emphasis on a "same" verb as prior marks agreement, while emphasis on the contrast verb indicates disagreement. See Sacks (1992 [1972], lecture 4:6, 10–11).
4. When the strategy of listening for talk in which the parents would allude to the existence of a difficulty is not successful, a regular practice is for the clinician to seek agreement on recipients' reason for visiting the clinic, which implicates "resistive" parents in producing or assenting to some particular complaint about their child because it is that which brought them to the clinic in the first place (Maynard 1991a). In other words, if parents think there is "no problem," and clinicians do think there is, the latter proceed to remind the parents of why they came to the clinic. In circumstances that mirror this, where doctors find "no problem" and patients believe there is, Heath (this volume: 256–7) shows that patients then offer to explain why they came to the clinic.
5. Thus, the series of turns may share the character of an "embedded" correction sequence (Jefferson 1987: 88):

   1 A speaker produces some object (X).
   2 A subsequent speaker produces an alternative (Y).
   3 Prior speaker produces the alternative (Y).

   And therefore, it seems that a part of the clinician's job is to correct lay perspectives. However, the interjection of agreement tokens before the alternative term in example (3), rather than rejecting an initial formulation as in a correction sequence, initially accepts and thus confirms that formulation.
6. Dr. H nevertheless went on to praise the mother for "feeling that way" because it showed a "positive attitude," and neither party returned to a discussion of the retardation term. Further discussion centered on the girl's need for affection, praise, and other forms of reinforcement. However, when the clinicians later recommended taking the child out

of parochial school so that she could attend a special class in the public schools, the mother would not go along with this recommendation.

7 Analyzing this interview requires glossing some details and segments that would take excessive space. My goal is to be responsible to these details and what goes in those segments, so as not to distort excerpts that are abstracted herein, and yet to concentrate on these excerpts as showing patterns that are invariant across at least the present corpus of data.

8 See the discussions in M. H. Goodwin (1983: 665) and Maynard (1985: 5–7) regarding how oppositional utterances can be handled in ways that accomplish repair or correction rather than in ways that implicate dispute.

9 The clinical position with regard to diagnosis, therefore, may be relatively rigid due to the intractability of institutional remedies (Mehan 1991). Nevertheless, while such institutional intractability may partially explain the origins and rigidity of the clinic's position, it does not account for the manner in which it is presented to the parents. The perspective–display series and its related mechanisms are persuasive devices, that is, but of a particular type. As clinicians work to co-implicate recipients' view in the delivery of diagnostic news, it displays a mutuality of perspective that gives at least the appearance of social solidarity rather than institutional imposition. See Maynard (1991b) and the conclusion of this chapter.

10. In general, "identifying" and similar devices for co-implicating a parent's perspective do not occupy distinct positions in a diagnostic news delivery series, but rather are relatively "free-floating" resources that can be introduced in a contingent manner at relevant interactional junctures on behalf of confirming, reformulating, upgrading, or elaborating a recipient's perspective. Thus, in one interview (no. 52), a clinician, Dr. V, apparently noticed some emoting on the part of her recipient, and broke off from confirming a mother's view that her child had a language difficulty to acknowledge how "scary" it was to come to the clinic. Dr. V went on to say, "Now I am a parent, ... and when I come in the first you know moment in the day I'm very struck by the building and the sign on the door [which refers to mental retardation] and it turns me off too and it's a very nervous feeling." Mrs. S, the mother, replied, "I agree with you." Thus, Dr. V proposed to identify with Mrs. S through categorizing herself as a parent, and proffering feeling-state descriptors with which Mrs. S could expectedly affiliate. The agreement from Mrs. S would suggest that the proposed identification was successful. After this, Dr. V returned to confirming the parent's view of there being a language problem, and reformulated the condition as a "trouble in verbalizing, in speaking." She later upgraded the diagnosis to "learning disability." Thus, identifying is not just a preparatory or anticipatory technique to be employed in immediate conjunction with presenting an upgraded diagnosis, but can

be utilized at any point in the delivery sequence (here, before a confirmation) where a recipient's emotional state "leaks through." In the conclusion of this chapter, see also the discussion of "identifying" as it occurs in the context of a straightforward diagnostic news delivery. And for a roughly similar organizational phenomenon, see Jefferson's (1988: 427–8) discussion of how "big packages" in conversation (such as troubles tellings) may not themselves have a strict ordering of constituent parts, but consist of smaller sequences that are only "loosely linked," and sometimes "interchangeably positioned."

11. Of course, delivering the diagnosis of brain damage transpires at some distance from the recipient's invited and initially displayed perspective. The significance of this lies in the temporality that thereby becomes an ineluctable aspect of the news-delivery process. Sequential distance between recipient's perspective–display and clinician's delivery of an official opinion translates not only into an increase in clock time according to the number of devices employed to co-implicate recipient's perspective, but may then permit an "inner time" (see Garfinkel 1967: 166) of anticipation and expectancy to develop as the participants move towards the interview's culmination.
12. In a pediatric cardiology clinic, Silverman (1981) has identified a persuasive use of perspective–display sequences as used to discuss Down's Syndrome children. By employing what I call unmarked queries, clinicians focused away from the children's medical difficulties and on their value as family members. This was to encourage parents to avoid having surgery done on the child and to respect his or her "social utility." With parents of other (non-Down's Syndrome) children, clinicians more often used closed perspective–display invitations and thereby displayed a willingness to deal with medical and particularly heart problems.
13. See the "Roberts" example and discussion of it in Maynard (1989b).
14. See also Heath's (this volume: 250–1) discussion of how doctors may propose an assessment and invite the patient's confirmation. Also, patients will sometimes offer their version of things after the clinician's delivery. But they do so without challenging the physician's assessment (Heath this volume: 257–9).
15. In regular medical consultations, Heath (this volume: 240) demonstrates that patients often do not talk after practitioners provide an assessment or diagnosis, "despite the practitioner specifically providing a position, immediately following its delivery, where the patient might 'properly' speak."

findings cannot be appreciated fully without knowledge of the stigmatization of mental retardation in sec. V.