12 Preserving and Constraining Options: "Okays" and 'Official' Priorities in Medical Interviews

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This analysis of medical interviews begins with what physicians themselves have identified as a recurring problem in need of resolution by means of elimination: the use of "Okays" in clinical interactions. Physicians' claims have not emerged solely or even predominantly from self-reported intuitions based on interview experience. Rather, observations regarding the problematic nature of "Okays" are drawn from actual examinations and reviews of videorecorded interviews involving third-year medical students. As will be discussed, the patterns identified and findings put forth are rooted in an educational mission designed to minimize dysfunctional while maximizing appropriate clinical behaviors; the ultimate concern rests with enhancing the quality of doctor-patient communication and thus the possibility of positive healing outcomes.

Beginning an analysis with an initial consideration of physician-identified problems is a somewhat unique point of departure for researchers attempting to understand the practical organization of institutional conduct (e.g., Boden & Zimmerman, 1991; Drew & Heritage, 1992). Yet such a move seems particularly warranted for purposes of this study. First, considering the wide spectrum of interactions comprising work settings, it is indeed rare for professionals to rely on the details of interactional involvements as resources for understanding (and attempting to improve the daily operations) of the very bureaucracies in which they are integrally involved. Second, and relatedly, it is also uncommon for social scientists concerned with everyday language use to be in a position to contrast their observations with those institutional members treat as significant-and to do so by relying on similar methodologies (i.e., recordings and transcriptions) for gaining access to naturally occurring interactions.

On the contrary, the daily work of physicians routinely involved in rn-+-6"..

interviews with pa ents is typically distinct from analysts' procedures for making sense of how inte ews get organized (e.g., by examining relationships among "questions" and " swers"). But throughout the interactional materials addressed here, it becomes p ssible to reveal both similar and noticeably different concerns held by clinicians d analysts alike. And perhaps even more importantly, sys- tematic attention c be given to a routinely taken for granted, seemingly small and inconsequentia feature of talk-in-interaction: the use of "Okay" in clinical set- tings.

In one very im rtant sense, it is shown that although "Okays" are barometers indicating just wh activities are treated as relevant by and for participants, re- currently designed o resolve emergent and contingent problems, "Okays" never- theless index only artial solutions to ongoing problems. It becomes increasingly clear that "Okays" are meaningless by themselves because removing "Okays" from their immedia and surrounding environments delimits the possibility of un- derstanding the wo k providers and patients are collaboratively producing and ne- gotiating. Best and rstood as interactional resources for organizing not just any, but recognizable an i particular kinds of activities, "Okays" are decidedly not iso- lated discourse "to - ns" but display precise orientations to more encompassing in- volvements: gene ly speaking, with the kinds of activities constituting the rou- tine organization d achievement of what are typically referred to as *topics, agendaslgoals,* and *identities/roles* in casual as well as institutional discourse.

More specificall the following interactional materials reveal how "Okays" iocument, by their ery placements and constructions throughout the discursive question-answer o anization of interviews, a remarkable and subtle variation of liscourse functions Of particular interest, however, is how "Okays" are recruited :)y physicians to gui e, direct, and otherwise control the initiation and elaboration A topics: often and imultaneously *toward* matters deemed relevant for achieving `official" clinical b siness, and *away* from what patients may be pursuing that may :)e treated by clim i ans as less relevant and important; systematically closing]own/moving awa from nonclinical concerns while opening up/getting back :o/working toward e underlying clinical focus of an interview.

As becomes evid nt, the very fact that it is physicians who overwhelmingly em-)Joy "Okays" reflec s, in the vast majority of cases, what has become a well rec-)gnized set of fmdi gs (cf. Drew & Heritage, 1992; Markova & Foppa, 1991) re- ;arding the "asymm try" of resources involving interactions between institutional authorities and lay rsons: Given the predominance of questions and answers and, more specific ly, "prefaced" questions, cf. Heritage & Sorjonen (in press); 3orjonen & Heritag 1991), institutional incumbents routinely engage in such ac- ivities as relying on "next question" to selectively determine what or if some por- ion of a prior answ r counts as an adequate response, what issues may or not be ;laborated upon, an (particularly in medical interviews) even whether or for what luration patients' e periences will be talked about (cf. Byrne & Long, 1976; 'rankel, 1990; Heri ge & Greatbatch, 1991; Mishler, 1984; Silverman, 1987).

These and related contingencies are apparent in the interactions examined here, reflecting varying degrees of difficulties-from little or no troubles marking adequacy of response, to putting on hold and even disattending patients' contributions altogether. Yet in all cases it is shown that "Okays" are relied on to facilitate the likelihood that specific kinds of "official" actions will be accomplished, at once preserving physicians options while essentially constraining patients' behaviors. Also apparent are ways patients are responsive to physicians' "Okay" usages as attempts to impose interactional structure. Throughout the negotiation of these types of moments, however, clinicians and lay persons alike display careful recognition that "Okays," regardless of placement and construction, are of practical importance and thus are consequential throughout the organization of clinical interviews.

Analysis begins with a brief overview of the teaching-learning mission in clinical settings, including descriptive-prescriptive consequences for clinical practice. Next, a summary is provided of the rationale underlying just how a case has been made that "Okays" should be eliminated altogether in interviewing. By re-examining a single interactional segment, initially provided as evidence of physicians claims regarding the dysfunctional nature of "Okays," a foundation is laid for contrasting physicians' claims with those emerging from social scientific concerns with naturally occurring institutional discourse. This creates a basis for describing how "Okays" are implicated in "topic organization," but also stresses why analytic concerns with "topic" per se ultimately limit understandings of how and what "activities" are being co-constructed in medical interviews. By examining alternative usages of "Okays" in the context of their usage, and by tracing cross-situational "Okay" usages in terms of how they arise within and are recruited to achieve numerous clinical tasks, attention can be drawn to similar yet arguably distinct usages of what might otherwise appear (and wrongly so) to be an unimportant or even constant interactional resource for physicians.

RECORDINGS AS RESOURCES IN CLINICAL SETTINGS

Recordings of provider-patient interactions are routinely employed as a teaching-learning resource for understanding how clinical relationships become interactionally created and sustained. Not atypically, focus rests with how specific kinds of behaviors are consequential for such interrelated and key activities as building trust, asking and answering questions, eliciting complete disclosures and histories, making efficient and accurate diagnoses, seeking compliance for prescribed regimens (i.e., as remedies for ongoing troubles), offering specific and constructive advice, and in general promoting "healthy" interactional environments wherein "healing" is collaboratively yet optimally attained over time.

In medical schools, for example, faculty and practicing clinicians increasingly rely on video review sessions to facilitate and refine interviewing techniques displayed by medical students, residents in training, and in some cases patients and

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ell. Basic procedures are relatively straightforward: Follow-
-playing medical interviews, participants review their record-
experienced faculty/clinicians. Throughout several hours of
s, technologically aided by options such as freeze-framing
layings of selected interactional moments, attention is drawn
havioral displays and interactional contingencies. On a case-
g discussion may address and reinforce positive and arguably
g techniques. Similarly, the identification and elimination of
more or less dysfunctional behaviors or patterns is also a top
e overriding concern, and understandably so, is to minimize
rs leading to problematic understandings and conflicting re-
ng positive healing outcomes.

irected, interactionally grounded review sessions is both in-
nsable for generating real-time and situated explanations of
d through medical encounters. No source of data better re-
teractional conduct than audio- and videorecordings of actu-
appropriate, transcriptions as well).

rent problems in work of this sort, many of which are not eas-
tice, quite the contrary may be the case. One central problem
lows: Do explanations offered accurately depict the interac-
f provider-patient encounters on their own merits?

underly why such difficulties should neither be overlooked
unted as untimely or peripheral to the teaching-learning mis-
the inherent density and thus complexity of the interactional
tigation. It is no small matter to identify, recognize, and sub-
stence of some interactional "phenomenon." Such work ef-
unt to generating empirical claims about how participants, in
d for themselves and in these ways made available for an-
tually "brought off" the activities claimed to have occurred:
employed, what particular orientations and thus understand=
y participants in the course of achieving specific kinds of sit-
st how does such talk-in-interaction progressively shape the
f medical interviews?

related questions only begin to address the fact that just as
al behavior is consequential for shaping real-time interaction
ce), so do analytic claims offered about the organizing fee-
s impact the kinds of understandings generated regarding
g" as a social, practical accomplishment. Relationships
and explanations of actions-in-context are inherently prob-
prescription (i.e., how clinicians *should* behave) appears all
s is not to say, of course, that attempts to refine and im-
e should be avoided. However, to prescribe the enactment of
ile eliminating others does presuppose some sense of *dis-*

cernment between "positive" and "negative" (and versions thereof, i.e., "good from bad," "productive from unproductive," "healthy from unhealthy," "trusting from untrusting," "warm from cold," "healing from nonhealing," and so on). And this begs yet further questions: How accurate are prescriptive discemments? By what criteria are such critical judgments made, reasoned, and subsequently implemented into clinical practice? What are the practical consequences of "prescribing" courses of action in clinical settings? Ultimately, what reflexive understandings might be generated by attempting to systematically address "description explanation - prescription" interrelationships?

For all practical purposes these concerns are, no doubt, sufficiently broad and encompassing so as to face the danger of being unanswerable. Perhaps such danger can be put on hold, however momentarily, by considering one set of conclusions (generated by physicians) regarding "okay" usages in medical diagnostic interviews, and then contrasting these findings with inspections of a wider variety of clinical interactions.

WHEN AND HOW "OKAY" IS DETERMINED "NOT OKAY"

Reliance on videotaped interviews to refine techniques for relating to patients and family members has been an integral part of the Rural Physician Associate Program (RPAP), created in 1971 at the University of Minnesota Medical School by Dr. John Verby. Throughout rural communities in Minnesota, it is reported that more than 500 rural physicians have worked with some 600 third-year medical students as a means of grounding and thus facilitating their medical education in practical situations of choice and action. Videotaping and reviews (lasting from I to 2 hours) with RPAP faculty occur within the first 2 months and are repeated within months 4 or 5 and 7 or 8. In an article entitled "Ok is Sometimes Not Ok", Verby (1991) reported that reviews and analyses of these interviews revealed:

> a remarkably repetitive and inappropriate use of the word ok (defined in *Webster's Dictionary* as approval or endorsement) ... This encourages the RPAP student to be sensitive to and aware of the destructiveness of using the word ok as a response ... approximately 50% of the students recognize they are inadvertently reinforcing some harmful behaviors and the inappropriateness of this phenomenon ... Given the use of ok as a response to patient answers, the patient may think the doctor believes smoking, drinking, or other potentially harmful behaviors are acceptable. Additionally, an ok response also conditions and prepares patients to wait for the doctor's next question, forcing the student to work and interrogate harder to obtain necessary personal information. RPAP faculty use direct confrontation and suggestion to eliminate the use of the word ok in interviewing. This is done simply and requires little explanation to the student physician.

As evidence for these dysfunctional claims of "Ok," and corollary attempts to lleviate usages in in eeviews, Verby provided the following "typical scenario" (S = student; PJ = pati$_e$nt Jones):

Exemplar 1 (Ver : "Ok is sometimes not ok")

S: "Mr. Jon I'd like to find out about your habits an lifestyle. Can you give me an idea of how much alcohol you use in a week?"

PJ: "Oh, about a six-pack of beer."

S: "Ok. What about tobacco?"

PJ: "About two packs a day."

S: "Ok. For how long?"

PJ: "About t enty-five years."

S: "Ok. No I want to ask you about drugs."

~s readers are not explicitly informed that this is a transcription of an actual in--rview, one where the patient's anonymity was protected by reference to the eneric "Jones," we trust infer that the "typical scenario" provided is, in fact, typ- ied: A general, reconstructed instance invoked by Verby to provide sufficient ev- ience of claims offered ed (i.e., that "This style of questioning ordinarily continues iroughout the interview").

From these data it may be useful to consider five sets of issues emerging from ie source and natur of multiple claims made by Verby (1991) and, apparently, greed upon by RPA faculty and students:

1. "Okay" usage§ are "remarkably repetitive" in medical interviews.

First, why "remarkably"? Data reveal that "Okays" are routine features in both veryday casual conversations and across a wide variety of institutional interac- ons (cf. Beach, 1993a; Jensen, 1987), they are frequently used and relied on, al- iough almost exclu$ively by medical authorities and only in specific cases by atients (as apparent! following sections). Yet just how frequently they are em- loyed, and in what kinds of interactional environments, raises a surprisingly com- lex set of issues not yet fully addressed. Clearly, "okays" are recruited as :sources to achieve articular kinds of tasks, but typically (as is also shown) not illowing each patient response. Following Exemplar 1, it would be easy to con- lude that "okays" a e nearly mandatory prefaces to physicians' next questions .c., "Okay-preface questions"). And although this is by no means the case in aturally occurring r terviews, the frequency and apparent foci of "Okay" usages re revealing when determining what is "at stake" in speech exchange comprising iscursive medical interactions.

2. *Webster's Dictionary* defines "Okay" as "approval or endorsement," thus sages in interviews are "inappropriate ... [destructive] as a response ... inad- ertently reinforcing some harmful behaviors."

For analysts of language and social interaction it should come as no surprise that dictionary listings of words and their literal or figurative "meanings" (as well as spellings, pronunciations, origins, semantic groupings, and the like) not only fail to capture utterances and their situated force, but, in these ways, social actions achieved through language. The long-standing attention given to manifold distinctions between what "what words *mean*" versus "what words *do,*" initially put forth in speech act theory (cf. Austin, 1962; Searle, 1969), began to reveal how words amount to actions having communicative impact (e.g., requesting, advising, suggesting, correcting, directing, complimenting, complaining, teasing, and so on). Yet the "theory" guiding understandings of "speech acts" has also been shown to be problematic, not due to overreliance on dictionaries to specify inherent meanings of words, but for similar reasons: An overreliance on isolated "sentences" (often contrived) to determine utterance force, situational definitions, a proclivity toward intentional and/or mentalistic explanations of behavioral/scenic displays of social order, and thus an inherent tendency to gloss or underspecify the systematic and salient features of conversational interaction (cf. Atkinson & Heritage, 1984; Beach, 1990b; Levinson, 1983,1992; Schegloff, 1984,1987a, 1987b, 1990; Searle, 1987; Streeck, 1980).' It is particularly in regard to this latter concern (i.e., a failure to take into account both the *temporal* and *sequential* features impacting, but also being shaped by, participants' orientations to moment-by-moment contingencies of interaction), that the clearest distinction between *conceptuallphilosophical* and *empirical* inquires is revealed: The former turns to resources (e.g., dictionaries, contrived sentences) external to the talk itself as a means of attributing consequences and thus imposing meaning and order onto social contexts; the latter attends to context (via recordings and transcriptions of naturally occurring interactions) by directly examining how actions-in-a-series are organized as participants themselves detect and display orientations to prior and subsequent turns-at-talk (cf. Duranti & Goodwin, 1992).

3. "Given the use of ok as a response to patient answers, the patient may think the doctor believes smoking, drinking, or other potentially harmful behaviors are acceptable."

In light of the prior discussion, it should be clear that these claims give rise to yet further questions and issues. First, how do reviews of "Okays" in videorecordings provide access to what "the patient may think the doctor believes"? What is the empirical status of "thinking" in medical interactions? Although there are no doubt times when patients explicitly disclose or inform the doctor about what they are "thinking," regarding a doctor's belief or otherwise, the analytic task

'This description does, of course, itself underspecify both the tenets of speech act theory and conversation analysts' rejection of such a "theory" as a viable resource for explicating the organizing details of social interaction. No attempt is being made here to cover ground readily available in cited sources. Rather, the kinds of claims made by speech act theorists, and the methods employed to generate these conclusions, are not altogether foreign to the instance and analysis provided by Verby in attempting to better understand the organization and practical consequences of medical interviews.

remains to interac:ionally reveal just how or if patients treat doctor's "Okays" as doing the work of "accepting or approving" harmful behaviors. Stated somewhat differently, how might doctors practically achieve "rewarding patients" (via "Okay" and by other means), and in what ways might patients orient to having excessive drinking and/or smoking accepted and approved by doctors? However relevant and interesting these questions and their potential answers might be, they address different interactional phenomena than those available by reinspecting three "Okay" usages in Student and Patient Jones. Although seemingly not a naturally occurring instance but a reconstructed and typified example, as noted earlier, it may nevertheless ?rove useful to consider how each of the three "Okay" usages are accomplishing different tasks (and, in so doing, also reveal the "typified" rather than "naturalistic" sense of these data):

Exemplar 2 (Verby, "Ok is sometimes not ok")

	S:	"Mr. Jones, I'd like to find out about your habits and lifestyle. Can you give me an idea of how much alcohol you use in a week?"
	PJ:	"Oh, about a six-pack of beer."
1-i	S:	"Ok. What about tobacco?"

Student's first "Ok." (1-*), for example, can be seen as marking adequate receipt of PJ's answer regarding alcohol, not atypically in *third turn position* following response to prior query (i.e., Question -4 Answer -4 Receipt (Ok) + Next Question) (cf. Beach, 1993a; Drew & Heritage, 1992; Frankel, 1990; Jensen, 1987; Mehan, 1979; Schegloff, 991a, 1991b). It is important to note that the work involved in employing "Okay" to display adequate receipt involves attempts to close down some or all feature's) of prior turn before opening the possibility for moving onto next matter (cf. Beach, 1990a, 1993a). At least in terms of everyday "casual" talk this altogether routine, transitional, and dual-implicative work of attempting to close down prior before moving to next is not "institutionally" synonymous with approving nor accepting of such alcoholic consumption (e.g., as with "That's okay" or "Okay goad" as forms of acceptance and/or positive assessment of some behavior or set of behaviors). In this typified case, the severity of drinking "about a six pack of beer" may or may not be indicative of alcoholic tendencies depending, of course, on PJ's history.

Yet notice that E does not, for example, provide a follow-up question pursuing additional informa ion about PJ's drinking, or in any noticeable way treat PJ's response as problem tic and thus deserving of further inquiry. Rather, S moves next and immediately t "tobacco" en route to related habits and lifestyle issues (e.g., drinking, smoking, drugs, eating, exercise, etc.):

Exemplar 3 (Ve by, "Ok is sometimes not ok")

1-~	S:	"Ok. What about tobacco?"

	PJ:	"About two packs a day."
2-4	S:	"Ok. For how long?"

Here S's (2-,) appears again in third turn position, marking adequate receipt of PJ's prior response, but in so doing does not attempt to close "tobacco" as an issue of inquiry. The alternative employed here is "Ok. + [follow-up question]," designed to seek additional information regarding "how long" PJ had been smoking "two packs a day,"

Exemplar 4 (Verby, "Ok is sometimes not ok")

2-4	S:	"Ok. For how long?"
	PJ:	"About twenty-five years."
3-a	S:	"Ok. Now I want to ask you about drugs."

to which PI responds with "twenty-five years." But again in (3-~), as with (1-a)-although unlike the follow-up question in (2-)--S marks receipt and moves to some next and related matter. But here S's "Now I want to ask you" re-formulates that an interview is in fact underway, at once informing PJ of what is coming next and more explicitly marking a shift toward "drugs" and away from "tobacco." As a result of the manner in which S achieves such a shift, there is more of a sense of finality to S's "Ok" in (3-a). Perhaps S's marked shift to "drugs" is somehow responsive to PJ's "twenty-five years" reporting? This is clearly an excessive amount of smoking, and S again comes off even more visibly in (3-a) as achieving some action *other* than "accepting or approving" via "Ok."

To summarize, from even these brief analyses it can be seen that "Okays" are accomplice to similar kinds of actions but variably so. In each of the instances shown here, S employed "Okays" as third turn receipt objects (i.e., Question -*Answer-) Receipt/Response) yet closed down prior and moved to next in recognizably different ways: In (1-*) S offered a no-problem response to PJ's prior response and moved directly to next question; In (2-,) S employed "Ok" pivotally to generate a follow-up question tied to PJ's "two packs a day" response. In (3-*) S's shift to "drugs" was particularly marked, possibly as responsive to the excessive nature of "twenty-five years." And in none of these instances can S be seen and understood to be achieving the work of "accepting and improving" PJ's harmful behaviors via "Ok", nor does PJ display an orientation to having been rewarded for such lifestyle habits.

4. "Additionally, an ok response also conditions and prepares patients to wait for the doctor's next question, forcing the student to work and interrogate harder to obtain necessary personal information."

Basic analytic concerns with such claims rest, of course, with what "waiting" and "work[ing] and inter;ogat[ing] harder" look like (i.e., how might they be identified as practical achievements and what is their interactional character?). However, neither is argued as relevant to the interview segment provided earlier, even

though it is appare t that PJ consistently withholds from producing fuller and more elaborated turns-a -talk. And further specific examples are not provided by Verby. At least on the su ace, therefore, these two claims appear minimally as underdeveloped and, perh ps, contradictory to the very work of "approving and accepting" attributed by Verby and discussed previously: *if* patients treat doctor's (student's) "ok respo ses" as somehow segmenting and imposing boundaries on a series of question answer paired actions, conditioning and preparing them to wait for next questions (which, as is addressed later, is not in certain environments an entirely inaccura claim), then why is it more difficult to "obtain necessary personal information ?

At least one re onable answer could be generated to such a query, en route to describing and ex laming certain "hypothetical" consequences noted by Verby. On one hand, patien orienting to "ok responses" as doctor's attempts to "condition/prepare" pate nts' behaviors (e.g., when they talk, what they talk about, and in what detail the address certain topics/issues/concerns) may come to treat ` ok responses" as atte pts to constrain, regulate, and otherwise close-down patient-initiated actions. liver the course of an interview one consequence may be eventual and purposiv withholdings by patients, making providers' work of eliciting patients' disclosur s increasingly difficult. Another involves elaborated speaking and thus continue bids for the floor by patients; a basic display of unwillingness to refrain from tal g about matters they deem relevant and important (see Jones & Beach, chapter , this volume). As is seen here, such matters often appear to not be anticipated by providers, and in many cases patients respond to providers' "Okay" placemen as premature attempts to constrain information they move next to volunteer.

Now it is by no means out of the ordinary to suggest that there are inherent and recurring proble s in establishing, coordinating, and maintaining mutual involvements in pro essional-client interactions. Heath (1984, 1986, 1992), for example, has amply demonstrated how both speakers and recipients rely on vocal and nonvocal res urces (e.g., gaze, gesture, postural shifts, kicks) as recruited components for particular courses of action, including the work of eliciting another's att Lion and response. Similarly, Frankel (1990) identified various ways in which ph icians display dispreference for patient-initiated questions, impacting how patie is design their talk in ways sensitive to speaker's rights and obligations in me ical encounters (i.e., interactional constraints shaping the unfolding character f physician-patient dialogue).

And, indeed, a wide variety of instances examined in this chapter qualify as types of "troubles Ik" (cf. Jefferson, 1980, 1984a, 1984b), replete with momentary interactional `asynchronies." However, the interactions examined do not generally involve he kinds of troubles as when speakers telling a trouble receive displays lacking ignment and/or affiliation from recipients (cf. Beach, 1993b; Drew & Holt, 19 8; Jefferson & Lee, 1981, 1992). Rather, in the data included

herein, physicians come off as trouble recipients who attempt to keep troubles-telling patients aligned with official tasks and purposes for meeting in the first instance.

Thus, in light of present concerns with what Verby described as "ok responses," the task remains to evidence whether or if patients respond to "Okays" by such actions as withholding and/or providing additional disclosures, thus influencing how providers may or may not work toward eliciting personal information. And if these sorts of actions fail to constitute the medical interviews examined, what alternative action sequences are implicated in and built-up around interactional environments involving "Okay" usages?

5. "RPAP faculty use direct confrontation and suggestion to eliminate the use of the word ok in interviewing. This is done simply and requires little explanation to the student physician."

The surety and definitiveness of this prescriptive posture is unmistakable. Verby reported that RPAP faculty have collaboratively identified the interactional work of "Okay" as harmful, seek to exorcise its presence in medical encounters, and are not inclined to substantiate their position to student physicians (a set of positions revisited in the conclusion of this chapter).

The subsequent discussion offers detailed consideration of these and related issues, providing an opportunity to assess positions taken by RPAP faculty and the prescriptive advice arising from such positions.

"OKAY" AS A RESOURCE FOR ORGANIZING TOPICS AND ACTIVITIES

Across a variety of casual conversations (cf. Beach, 1993a, in press; Button, 1987, 1990; Schegloff & Sacks, 1973; Schiffrin, 1987), within medical diagnostic interviews (Jensen, 1987), and across a wider variety of institutional settings (e.g., courts, 911 emergency calls, therapy sessions, classrooms, corporate meetings; cf. Beach, 1990a, 1991), preliminary efforts have begun to identify "Okays" as one type of acknowledgment token signaling and thus evidencing speakers' attempts to shift topics and/or activities. That "Okays" are frequently recruited by speakers to simultaneously close down some prior activity (e.g., by treating prior speakers' contributions as having sufficiently answered and/or elaborated upon a given issue), while also transitioning to some next-positioned matters, highlights an altogether pivotal and routine (though by no means exclusive) set of interactional usages.

The basic work and thus interactional significance of "Okays" may be grounded in and contrasted with Jefferson's (1981, 1993) empirical demonstrations revealing how "Yeahs" often function as recruited components for topic shift. As one

derstandings a d activities physicians and patients may simultaneously be *working toward.*

It is not u ommon, particularly in medical diagnostic interviews, for topic shifts to be ac eyed without a hitch. The basic three-part sequence described earlier as involve g "third turn receipts" and comprised of "Question -* Answer -4 ["Okay" + To is Shift], is easily recognizable:

Exemplar (Street: 2:5:4; arrow mine)
Dr: When did you first start having your periods (0.2) °how old were you°
(1.3)
P: Think I was thirteen
Dr: "Okay° an when did they get regular

Exemplar 1 0 (Street 2.5:5; arrow mine)
Dr: How many days in between yer periods
(5.0)
P: °Oh probably° (1.4) they usually la:st four days
(0.2)
Dr: °Kay° ya have a heavy flow?

In both exe plars the doctor treats the patient as having been responsive to the original questi n (or as in Exemplar 9, two questions), adequately answering and providing info ation being solicited. In third turn the doctors""°Okay°/°Kay°" display such p or orientations while also making way for next-positioned query. This appears t be the case even in Exemplar 10, where P's answer is *not* directly responsive to 's question (although the amount of days between periods may nevertheless deduced from P's answer).

Variations om this basic three-part sequence do occur, however, as when clarifications are e ployed to elicit not-yet-adequate understandings that, apparently, are prerequisit s to topical shifts. In the following instance, where prior to Exemplars 9 and 10 he patient's presenting complaint involved abdominal contractions and pains, in ne (1-i) Dr treats P's prior answer as insufficient-partially repeating and se king clarification by upgrading his original question from "usually" to "always regular";

Exemplar 11 (Street: 2:5:2-3; arrows mine)
Dr Er- are your periods usually regular?
(1.0)
((door opens))
Wh- dis the ftrs time in a long time
(1.2)

1-+ Dr: They're always regular?
(1.6)
P: Ever since I had ma las baby
[
((door closes))
2-) Dr: °Since ya had yer last baby° (0.3)
okay now you're seventeen
P: Mm hm
(2.2)
3-+ Dr: °O:kay° you saarted bleedin Sunday (0.4)
now Monday what happened

Following what amounts to P's second yet qualified answer, Dr essentially repeat P's prior response in (2-+) as one means of displaying and confirming receptio and understanding of the gist of P's answer (cf. Sinclair & Coulthard, 1975). 1 this way Dr builds on and comes to treat P's answer as not equivocal, but rather qualified and adequate "yes" (i.e., "always regular -4 ever since I had my Jai baby"), thereby reducing the ambiguity arising from Dr's first question and P's in: tial response (cf. Schegloff, 1984). Once achieved, momentary topic shift is the initiated via "okay now you're seventeen." And as responsive to P's unequivoc, "Mm hm," Dr's (3-+) once again receipts with "Okay + [next (prefaced) que: tion/topic shift]," an activity re-establishing prior focus on symptoms of the prc senting complaint ("periods") with a related medical problem ("bleedin").

In Exemplar 11, then, Dr's refocusing in (3-+) emerged as a consequence c prior work designed to insure that sufficient understandings had been obtained. I is only following partial repeats in (1-+ and 2-,) that Dr moves next to confirr P's age and, once completed, to move "back" yet "onto" next official matter-gen erating a history of events assumed to have direct relevance to the presenting com plaints of "abdominal contractions and pains." In this environment, Dr's "Okays added closure to understandings now refined, and in these ways remedied, via re peated clarification and confirmation; they also made possible the decided shil back/onto matters deemed relevant *by* Dr. In so doing, Dr preserved the opportu nity to treat a particular answer as insufficient, remedy the problem in satisfactc ry fashion, and then (but only then) re-initiate a trajectory of questions addressin symptoms and complaints. Thus, in Exemplar 11 we see that before shifting an moving forward in a diagnostic interview, Dr relies on such devices as partial re peats to seek clarification and display confirmation of prior answer provided by I Within these environments, "Okays" are recruited by Dr to display that some c all portions of P's answers are not only adequately responsive, but that certain urr spoken implications are understood and agreed upon in what appears to be a pre requisite for topical movement.

When "Okays" appear as third turn receipts employed by doctors, howeve they do not always preface immediate topical shift and forward movement (e.g

ize greetings, moves immediately to explain how "the E R" sent P to visit. Following P's brief acknowledgment ("Yeah"), D's "O:kay. What's happenin to you" solicits P's reasons for the visit.

In both exemplars, then, the doctor relies on "Okay" as one component for achieving the u sk of shifting orientation from preliminary matters to official business: describing what medical troubles the patient is experiencing that will shape **the nature and eventual focus of subsequent interaction.**

For purpose ~ of contrast and with regularity, so are "Okays" recruited for purposes of beginning to terminate a wider variety of clinical exchanges, similar to forms of "pre-closings" (cf. Schegloff & Sacks, 1973; but also see Beach, 1993a) in phone conversations as individuals collaborate in bringing talk to a close. The following example terminates a behavioral therapy session involving a client's problems with finding and retaining employment. (Th = therapist; C = client):

Exemplar 7 ;SDCL:BT/JD:IA)

	Th:	Try that in the mornings..hh certainly when you get home from school. (1.2) that should be your time to be:: compressed (0.5) get your- (0.6)
1-4		1 take the pressure off yourself olcl?
	C:	°(O)kay° ((whispered))
2-4	Th:	Allright
	C:	Oka y
		[1
2-*	Th:	We '11 see you o:n (.) Tuesday
-4	C:	Okay
		((End of Session))

Three observations might be made regarding "Okay" usages in this instance. First, in (1-)) the therapist relies on *a tag positioned,* upward intoned "olcl?" which is quietly receipted ('(O)kay) by C in next turn. Such utterance pairs are common when first speaker seeks some form of agreement and/or alignment from next speaker. But in this case it is important to not overlook how Th moves toward "beginning to end the session by offering therapeutic advice: "take the pressure off yourself olcy?". And via the next receipted °(O)kay° C not only displays a willingness to accept Th's advice, but also refrains from speaking further. By repeatedly passing on fuller turns, C makes possible the unproblematic movement toward closure that Th's "Allright + [We'll see you o:n (.) Tuesday" ("Allright" often functionir g in ways similar to "Okay" in the process of terminating exchanges) in (2,) further advances by also looking forward to their next appointment.

However, " kays" (and/or "allrights") can appear at a wider variety of moments other th beginning and terminating clinical encounters, including precise junctures marki g movement from "diagnosis" to "physical examination":

Exemplar 8 (CO-002: #2; Jensen, 1987; arrows mine)

	D:	have you found anything more difficult to do in the last six months
		( )
	P:	you mean physically or what
	D:	anything at all
	P:	Ya ( ) no not really
-a	D:	ok. ( ) all right why don't we go ahead n: check you over
-4	P:	sure ok

Although Jensen (1987) proposed an "apparent equivalency" between "okays" ai "allrights," with the possibility that "allright" offered a stronger signal and) marked more major transitions, here it might be observed that a distinction is me ited due to how D's 'ok" is decidedly local and backward-looking: invoked to a knowledge and treat P's immediately prior response as having sufficiently a swered D's query. Once achieved, D's "all right" officially moves to close the mo encompassing activity-the diagnostic medical history-while also transitioniu and setting-up the next-positioned physical examination. And as P's "sure ok" di plays alignment and thus a willingness to accommodate the suggestion D h made, a suggestion built into a question and receiving an answer from **P, y** another usage of "okay" becomes evident: signalling not just adequate recei but also a "no problem" orientation to the actions D is proposing (similar to F free-standing and "passing" "okays" in Exemplar 7). Involved less with the of cial initiation of shifting via closing down/opening up topics and activities (whip is decidedly D's work, providing D the opportunity to utilize the expertise assoc ated with medical authorities), and more with what approaches but is not qui "granting D permission" for a physical examination (which is nevertheless e pected and procedurally routine in most cases), P's "sure ok" doubly facilitates ai indicates involvement in switching from one phase of the medical encounter to a other.

PRESERVING AND CONSTRAINING OPTIONS: CONTINGENT PROBLEMS AND SOLUTIONS FOR TOPIC SHIFTS

It is clear, then, that just as clinicians are institutionally responsible for an occ sion's focus and purpose (cf. Beach, 1990a, 1994), so must they guide and din discussion through a variety of topics. As noted previously, attempts to acknoN edge, close down, shift, and move to next matter may be situated on a continua reflecting no or minor problems on one hand, to degrees of troubles in achievi such shifts on the other. These activities are dependent on both the kinds of t

predominant y minimalized acknowledgment token, "Yeahs" commonly precede not only mediate shifts in topic but also such actions as brief assessments (as well as corn entaries) leading to such shifts (e.g., "Ygh that's goo:d. u-How is your arthritis you still taking ahoas?"; Jefferson, 1993, p. 10).[2] However, although such "Y ahs" repeatedly come off as exhibiting attention to what speaker was projecting n prior utterance, and doing so in the very course of shifting to some next matt rs, it is also a clear display of a "recipient working to disengage from a topic in ogress in order to introduce some other matters" (Jefferson, 1993, pp. 27-28) - e orts toward topic *attrition* in attempting to bring to a close whatever trajectory r topical line is being pursued, thus underway and in progress, by current speaker.

Attempts to nderstand these kinds of topical activities (cf. Redeker, 1990; Schiffrin, 1987) also emerged from classifications of "okays", among other discourse *markers r particles (e.g.,* well, now, so), as devices employed to manage episodic bound es and to *bracket* defining units of talk: for example, beginnings, endings, and/or ore subtle movements toward topic shift (cf. Goffman, 1981), including facili ting the "cadence and pulsing activity" of various classroom tasks (cf. Sinclair & oulthard, 1975). Of particular relevance to the ensuing analysis, however, is wh t appears to be the only inspection of "okays" in clinical settings: Jensen's 1987) examination of "Okays" in 12 diagnostic medical interviews (acros six physicians). Describing "Okays" as "bracketing devices" marking beginn gs and endings of tasks in the specialized context of diagnostic interviews, atte on was given to how "Okays" reflect physicians' techniques for "pacing and pun tuating" (p. 53) interviews by their placements within and across question-answe sequences; "Okays" were found to routinely separate both individual questions and answers, and in other cases mark boundaries among clusters of topically rel led questions comprising interactional segments of varying lengths.

One key con nn raised by Jensen regarded the *generalizability* of results within a larger colle tion of medical diagnostic interviews.' The analysis proceeds by overviewing an elaborating on several of Jensen's findings, and also by offering comparisons wit other interviews.

'See also the "c lloquy" on attempts to quantify these shift-implicative features of "yeah" in *Research on Language and Social Interaction, 26,* 1993, pp. 151-226.

[3]Concerns with *eneralizability* may also be raised across different, although related kinds of clinical involvements (e e, family therapy, behavioral therapy, and pregnancy counseling sessions). Such comparative work is ongoing, and provides useful contrasts with role- and task-specific activities of professionals other t physicians as they proactively structure medical interviews (cf. Beach, 1994). In fact, examinations of how therapists and counselors engage in such activities as "preserving and constraining options" w ile working to maintain an "official" focus through sessions reveals, and quite clearly so, just how rural and discursive most medical interviews actually are.

Beginnings, Endings, and Recognizable Junctures

An understanding of how "Okays" are adapted to achieve particular and larger tol ical tasks in clinical settings can begin by noticing that an "Okay" can indicate a tempts to officially begin and terminate medical encounters (as with phone opet ings and closings in casual encounters, cf. Beach, 1993a). Two straightforwai "opening" instances, drawn from separate medical diagnostic interviews, appel here (D = doctor; P = patient):

Exemplar 5 (CP-014; Jensen, 1987, p. 35; arrow mine)

D: why 'ncha sit over here Mr. B- (an its gonna
be a little ( ) hhhh (.) closer ((cough))
( ) to this machine ( ).hhhhhhhhh ((cough))
an we'll jes kinda ignore it hhh.
((sound of turning pages))

-4 D: ok what can I do ya hhh. ( ) what's happening

Exemplar 6 (Street 2.5; arrows mine)

D: Hello?
P: Hi =
D: =I'm Doctor Wilkensen
P: My name's (Dawn)
D: Pleased to meecha
P: °Me too°
D: Ya visited the E R en- (0.8) they said no
we- wanna send you over here
P: Yeah
[l
9· Huh huh huh
D: O:kay.
?: Uhuh
D: What's happenin to you

In Exemplar 5, D brings to a close the work of getting situated for the interviei where the patient sits, what appears to be explaining the necessity to sit closer the "machine" (a recorder to be ignored), and turning to appropriate pages for cr ating a medical record of the event. Once completed, D then relies on "ok" in tra sition to the official business-"what can I do ya hhh. ( )what's happening="- two separate, although related queries, the first revealing D's recognition that tl patient has a medical reason for visiting, which D can hopefully assist with, ti second a general invitation for the patient to describe the nature of the problem(to be addressed. And in Exemplar 6 notice that once the doctor and patient fins

as with 3-4 in xemplar 11). In Exemplar 12 Dr's "Okay"-prefaced query in (1--4) emerges, and d licately so, as a consequence of both P's prior answer to the original question ('Yes maam") and the subsequent explanation offered by P ("but u:h . . ."). This tterance essentially *partitions* the two components of P's answer and handles ea h differently:

Exemplar 1 (Street:2.6:3; arrows mine)

	Dr:	Did you realize at that time that you had hurt yourself?
		Yes maam but u:h (0.6) I still had Iwo hours before I was off
1		T Okay so you went ahead and worked?
		[
2-ii	**P:**	So
3-,	**P:**	Yes ma'am
		(0.8)
4-,	**Dr:**	What- < what did you notice hart after >
		(0.2) the accident

In (1 -4) a deci ed backward-looking focus can be observed: Although Dr's "T Okay" treats P' "Yes maam" as sufficient, it simultaneously enforces closure upon and thus constr ins further elaboration by P (commentary that at this point remains incomplete, as s readily apparent with P's "So" in (2-+). Next, in lieu of and thus as a replaceme *t for* P's talking, Dr's "so you went ahead and worked?" addresses what was im lied yet unspoken in P.'s prior elaboration. Of interest here is how Dr provides a nse of what P may very well have specified had Dr not moved to constrain furth r talking by P. Notice, for example, the overlapping and simultaneous producti n of "So" by both Dr and P. Moreover, P's turn-initial "So" is placed immedi tely following Dr's "T Okay." Yet in recognition of Dr's imposed closure and ob ious continuation, P withholds speaking further until Dr's utterance completio . And only then does P in (3-4) answer Dr's query with a terminal "Yes ma'

Dr's query (1-4) can now be seen and understood as an effective substitution for the v point P was working toward. But additional work is being achieved here b Dr, namely, the employment ofa delicate and precisely timed device for pre-em ting P's continuation and insuring that a minimal yet sufficient answer has been o tained. Dr not only retains speakership but, via the query in (1--~), obligates a part cular kind of minimal answer from P. And having now received two unequivoc answers from P, Dr is in a position (in 4-p) to shift and move forward to related 'official" business involving what P noticed that "hurt after (0.2) the accident": position generated and preserved by not just constraining P's options to continu but also soliciting from P what Dr treats as a suitable response, one making po sible forward movement in the interview.

There is also a hint of another emergent problem in Exemplar 12; (see also E) emplars 13-16) involving P's overlapped "So," namely, simultaneous and overlapped speaking by both Dr and P.[4] In this instance the problem of determining who is to speak, for how long, and on what topic is immediately resolved due t both P's discontinued speaking and (in 4-4) Dr's movement to the next questiol Yet this fleeting moment is nevertheless reflective of the collaborative work ne(essary between Dr and P in jointly managing floor access and, ultimately, ways i which topics get raised, elaborated upon and/or brought to a close (and, of cours(by whom).

In Exemplar 13, for example, Dr and P are addressing P's recent and painft back problems:

Exemplar 13 (Street:2.6:5; arrows mine)

	Dr:	You kept thinking it'd get better
	P:	Yeah
	Dr:	Then it didn't
		[[1
1-4	P:	Hoping it would get better because you know I have to work
		(1.2)
2-*	Dr:	T Ka:y I don't know too much about cars, tell me (.) how heavy is an intake manifold

Following P's "Yeah" response to Dr's initial query, Dr and P simultaneously begin speaking at the next turn-slot: Dr begins to ask a follow-up question precisel; when P elaborates by qualifying prior "Yeah" answer-a continuation that repeat: Dr's initial query by first correcting and replacing "thinking" with "Hoping...-f

`There are instances, however, where overlap and thus simultaneous speaking is avoided but similar problems remain to be addressed:

Street:2.6:6; (arrows mine)

	Dr:	As far as you know no k- kinna twisting of your back or anything
		(0.4)
	P:	No:t that I know of
		(1.0)
-j	Dr:	T Okay
	P:	T No
	Dr:	pt hh And since then it's been painful to move from side to si:de?

As Dr's "T Okay" initiates closing down prior, Poffers a delayed and more certain answer ("T No" that is neither in overlap nor pursuant of fuller turn/continued speaking. Treated as further evidence o an adequate response, Dr moves next to "And-prefaced query" and topic shift.

[explanation r garding work]". Here P's "Yeah" is responsive to Dr's prior query and does, al it minimally, exhibit attention to the problem of her back "get better." But in (1) it also apparent that P moves immediately to introduce what appears to be a atter of some importance: one form of reason-giving that could be heard as P's a tempt to *solicit* Dr's understanding, perhaps even commiseration, regarding P's redicament. For example, P's "you know" specifically addresses and essentiall invites Dr to **become** a coparticipant, one who at least acknowledges the pro lems P is facing. (Chapter 10, this volume addresses this issue.)

Notice, ho ever, that following an extended pause Dr (in 2-*) neither attempts to recycle and complete prior question withdrawn during overlap, nor address P's elaborated res rise and reference to "*work*." Instead, Dr relies on "T Ka:y" *not* as an acknowled ment of P's articulated problems, but as a resource for closing down P's introduce topic (i.e., relationships among "back pain" and "work"): in (2---*) Dr engages in activity *other* than treating P's reformulated answer and reasongiving as Buff ient, interesting, or otherwise worthy of attention. Rather, and en route to shifti g topical focus, **Dr's** "T Ka::y + [question]" essentially disregards and even igno es concerns nominated by P. Through such noticeably absent uptake, and thus by imposing such constraints on the very possibility of P's topic elaboration, sets up and preserves the option of seeking additional information about the app ent cause of the injury (i.e., what P was lifting when the back injury occurred) but now aligned with Dr's concerns and priorities.

And just h w this work gets done following "T Ka::y" in (2-*) should not be overlooked. ere Dr begins by *disclaiming knowledge* about "cars," through which two rim ly and practical activities are achieved. First, Dr's disclaiming is a particularly in ovative (although indirect) method for inviting P to assist Dr and actually colla rate in shifting away from (and thus essentially avoiding) what P had, only mo ents before, put forth as issues of some importance. Second, Dr's disclaiming is itself a form of reason-giving amounting to a justification for the very actions D has initiated. Viewed together, the inviting and reason-giving built into Dr's discl iming offers a uniquely tailored response to P's own prior reasongiving and sol itation.

For these r asons the delicate character of Dr's disclaiming, initiated via "T Ka::y," should not be discounted as merely coincidental. On the contrary, this utterance is prec sely and locally occasioned to facilitate a shift *away* from P's concerns and *tow* d **Dr's** priorities. It also sets up Dr's next "tell me (.) how heavy is an intake man old." No longer an indirect invitation but now an explicit charge prefacing Dr's query, P is now in an obligatory position to be responsive to what Dr has adeptly transformed from P's to Dr's priorities.

Turn-Transiti nal Environments

Within both E emplars 12 and 13, brief moments of overlapped and thus simultaneous talk aver apparent between physician and patient. Across turn-transitional environments ore generally, where bids for floor and speakership are (more or

less) competitive and continuous (cf. Beach, 1993a), "Okay" usages may apps free-standing but are typically prefiguring fuller turn and topic shift. In casual a institutional talk alike, "Okays" are routinely placed at or near what might be tre, ed as potential completion points of some prior speaker and thus are potential transition-ready.

For example, Jensen (1987) suggested that in such turn-transitional envirc ments physicians may routinely propose (via "Okay") that patients' answers a sufficient. One such instance employed by Jensen appears in Exemplar 14. He S initially overlaps D's question prior to its completion (I-->). Next, P continu to speak (2-3) even after D's first "ok" (3-3), thus beginning to "interjective delete" (Beach, 1993a) the pre-closing D's "ok" was attempting:

Exemplar 14 (CP-008:#1/#16; Jensen, 1987; arrows mine)

S= significant other

	D:	hhh ah did yer doctor in [city] do any kind of tests of any sort
	P:	(hm mm) =
	D:	= ekg: or blood tests or anything like that
1-a	S:	[l he had planned to th is w eek
2-*	P:	[ ] he h ad planned to yo u se e
3-*	D:	[ ] **ok**
2-a	P:	but I didn't go (.) ya know that means I'd had to go down (.) earlier than I'd like to n ( )
	D:	ya
2-,	P:	that's where I decided I was goin to get involved up the- in this area (you know)
4-p	D:	[ ] ok
4-p	D:	what sort of tests did he say he was going to do or did he have (any)

More specifically, Jensen (1987, p. 43) suggested that D's two ` ok's" (Lines 3. & 4-,) are tokening *acceptance* of P and S's turns, treating them as sufficient a savers to questions. This appears to be the case in 3-* (although P's ` ok" is st pre-figuring a fuller turn) where both S and P's responses amounted to what could make out as a "no" answer to prior question (cf. Jones & Beach, Ch. 2, tt volume. Yet in (4-4) (as with Exemplars 12 & 13) interactional work beyond "a ceptance" is involved: D's "ok" sets up the possibility of not having to addre matters laid out in P's explanation, essentially shoving off from the backgroui reasoning provided by P. Instead D returns to "tests," incorporating new inform

tion by shifting the question from past to present (i.e., "did doctor do -3 going to do"), at once ac ively avoiding further elaboration upon topics implied in P's back- grounding whil ensuring that "tests" be addressed as efficiently and sufficiently as possible (an again, not coincidentally, on the doctor's own terms).

It is in this ay that D's closing "ok" in (4-4) is every bit as much *a rejection* of P's potentia topic nomination as an *acceptance* of the sufficiency of P's re- sponse. This is ot to say that clinicians do no rely upon "Okays" for straightfor- ward acceptanc of some prior response. But (Exemplar 14 4-3) does not appear to be such a ca e, as little or no acceptance per se is displayed by D. [5]

In terms of hether patients may reject doctors' attempts to close down and shift topics via 'Okays"-not unlike P's (2-a), in Exemplar 14, described earlier as an "interject ve deletion-Jensen (1987) began to address how patients may continue spe g despite what "Okays" might be projecting:

Exemplar 1 (CO-014:#19; Jensen, 1987; arrows mine)

D:	do you walk up the hill daily
	( )
P:	jest about ( ) but I 'n I walk from my house
	(it ah:::) out by (name) park
D:	mhm=
P:	= to my office (.) (in my) (name) school every
	day.
	( )
1-, D:	OK
	( )
P:	usually both ways (.) (when) in decent weather
2-4 D:	OK( ) tch .h um:: ( ) do you have asthma

Put simply, spe ers to whom "Okays" are addressed may themselves disattend such pre-closin attempts with continuation, creating points of negotiation over floor and topica boundary issues. Yet it is important to stress that in Exemplar 15, other data provi ed by Jensen (1987) as evidence of these claims, and further med- ical diagnostic ata available for inspection, patients' continuations are *momen- tary* problems t be resolved; no cases have been found where patients absolutely refuse to adher to doctors' attempts to shift topics toward what they prioritize as more important and relevant "official" matters (i.e., when accomplishing such

SThis raises the problematic questions of (a) determining whether "displaying acceptance" and "treating a respon as sufficient" are functionally equivalent descriptions, and (b) whether orienting to prior turn as "su cient" is functionally equivalent to such actions as "closing down, disattending, failing to elaborate pon" and similar ways of accounting for the work of some next speaker's way of managing options a ailable from prior speaker's tum-at-talk. Although an extensive discussion of these issues, and theirdiv rse implications for understanding both casual and institutional interactions would be useful, it rests be and the focus of this chapter to elaborate on such details.

tasks as "revealing a medical history," "creating a medical record," "retrievin facts for necessary for diagnosis," and so on.) And although Bergmann's (1992 analysis of psychiatric intake interviews has revealed several kinds of "explosiv reactions," and at times a lack of cooperation by patients (see also Erickson J Schultz, 1982; Labov & Fanshel, 1977), such has not been found to be the cas with the medical interviews examined for this chapter.

By reinspecting Exemplars 14 and 15, several common features become no ticeable: (a) P is caught up in producing a fuller description than D may have "pre ferred"; (b) at transitional/opportunity spaces, D relies on "Okay" in ways treatei by P (via continuation) as premature movement to closure; (c) yet in orientation ti D's pre-closings, P works to immediately (or in "real time", nearly so) bring un solicited and elaborated turn to a close. No attempts are made by P to display out right "rejection" of the trajectory initiated by D, if and when "rejection" is take) to be a problem requiring fuller attention and/or continued lack of compliance tt topical progression as initiated by D. Rather, P's talk is *designed* to come to a close *as responsive to D's "okay" placement*. And in the very next turn (as in Exempla 15), P does terminate speaking, giving rise to D's (2-,)"OK" repeat + [topic shif via next question concerning "asthma"].

Repeated and recycled "Okay" usages occur routinely across turn-transitiona environments, in large part as resources for dealing with ongoing continuations seemingly until and unless speaking is completed and the way is then made clea for "Okay" producers to initiate next action(s). I have referred to these repeater "Okay" placements as "Okays-in-a-series" (cf. Beach, 1991) that may appear con tiguously (typically from two to four in a row; e.g., see Beach, 1993a, and/or a: interspersed throughout an extended spate of speaking (the example of tw("Okays" in near vicinity in Exemplar 15 being one minor example). In most al cases, these serial "okay" placements are recruited components for attempting t(deal with some interactional trouble (e.g., attempting to terminate another's con tinuation in order to get back on track), and also to terminate what are themselve: treated as particularly troubling topics or activities. Across such usages, the rulr of thumb appears to be the more "Okay" usages, the greater the trouble requirinf resolution ("closure" being only one instance).

This can begin to be seen in a final instance drawn from medical diagnostic in terviews, one initially examined by Jensen (1987):

Exemplar 16 (CP-014:#20; arrows mine)

D:	=m hm ( )have you ever had pneumonia?
	( )
P:	no
	( )
D:	tuberculosis skin test do you know?=
P:	=ya ( ) I've had that it (I its all)
	comes back positive

D: always positive=
P: =m hm
1-* D: ok
P: cause (that way) I guess I been in contact
with people that had ( ) active tb
2-4 D: a ha=
P: =or slept next to em in jail
3-~ D: ok ( ) ha ha yes::
[1 [1
P: (ya know) but
P: it comes up positive every time
4-* D: all right ((chuckling)) ( ) hh um:::
( ) any trouble with your urinary track

Here D's initial 'ok" (1-,) is employed as a third turn receipt to P's confirmation of D's prior qu tion, and as noted previously immediately precedes no-problem topic switches. However, P continues by providing an explanation ("cause. .."; see also Exemplars 12 and 13) which D next receipts ("a ha" in 2-*) with a token of special understanding or realization (cf. Beach, 1990a). As P continues speaking, it is worth noting that D's (3-a) *escalates* the attempt toward closure in trimarked fashion (i.e., 'ok + laugh token + yes")--one method for integrating alternative resources to increase the likelihood that worked-toward consequences will actually be achieved-in this instance by laughter that betokens appreciation for P's prior and potentially humorous utterance, and a "Yes::" that (as Jensen, 1987, observed and as discussed previously) displays a possible shift-implicative bid for speakership. And finally, as P finally brings his unsolicited contribution to a close D's "all right" (4-4) does seem to more forcefully terminate prior extended discussion, albeit not without mitigation and some sensitivity to the gist of P's comments (i.e., by relying on "chuckling" in the midst of closure and transition to "topic shift via ext question").

SUMMARY AND IMPLICATIONS

The prior analysis examined diverse and locally occasioned "Okay" usages across selected medical diagnostic interviews. Findings reveal not only the indispensable utility of "Okays" for achieving diverse institutional tasks, but even more centrally how "Okays" are situated within encompassing courses of action involving what are often delicate negotiations between providers and clients. Such negotiations are often reflective of alternative orientations to "official" business at hand, even though occasions as medical interviews are uniquely tailored to (and in search of solutions for) lay persons' problems. Thus, one common set of problems requiring constant resolution involves physicians' attempts to keep the interview "on track"

with "official" business at hand-a focus on issues treated by clinicians as ir, portant that, apparently, patient-initiated actions such as continuations, indire answers to questions, and unsolicited comments can essentially "sidetrack" ((Beach, 1990a, 1994). Simply put, on such occasions it is not uncommon for cliff icians to rely on "Okays" as devices variously designed to constrain clients' tal and via subsequent queries attempt to bring talk back in line with particular to ics and points that, once again, are deemed relevant and worthy of pursuit en rou to achieving professional goals and priorities.

Although it was shown how participants may differentially work toward mo or less contrasting sets of relevancies and priorities throughout discursive ii terviews, in the vast majority of cases it is physicians who proactively recn "Okays." Generally speaking, in the course of guiding and directing topics and a tivities; seeking clarification and enhanced understandings as apparent prerequ sites to topic shift; simultaneously constraining patients' options while preservir physicians' abilities to initiate topic shifts by focusing on specific kinds of ne actions and priorities. As interactional resources physicians routinely rely o "Okays" are especially employed as partial solutions to ongoing problems, pa ticularly those treated as distracting to, or even momentarily in competition wit what "institutional authorities" are working toward in carrying out role-incumbe: tasks.

Consequently, even though a physician's "Okay" (as preface to immediate ne:

question and/or as free-standing) may come off as briefly acknowledging receif of what was taken to be meaningful in P's elaborated utterance, the opportunity assess just *what* and *how* an utterance (and portions thereof) is deemed relevar and toward what purposes, is reserved by and for physicians whose "Okay" make possible the option of following up on, momentarily putting on hold, or even di attending altogether what came prior in favor of moving to some next "officia matter.

Strikingly similar findings are beginning to be generated across a larger corps of institutional data, including more diverse clinical involvements (including fan ily, behavioral therapy, and pregnancy counseling sessions, as well as 911 phor calls, cf. Beach, 1994; Zimmerman, 1992). Yet in each case "Okays" are adapt(to the occasion at hand, replete with situated troubles and solutions reflectir emergent, altogether institutional, contingencies.

The diversity of "Okay" usages across the medical diagnostic interviews e amined herein reveals how it is problematic to assume that a given acknowled, ment token can be employed to achieve only limited actions. Such diversity w apparent across several discernible (although by no means exhaustive, and at tim overlapping) ways. To simplify, these usages are best arrayed on a continuum fro achieving work involving no or minor difficulties, on one hand, to increasing tro bles requiring remedy on the other. First, physicians may simply treat patients (v "Okay" as third turn receipt) as having been adequately responsive in prior answ to initial question. Second, "Okays" may precede partial repeats and/or dire

queries seeking c arification and confirmation of patient's prior answer. In these environments, "0 ays" may also display that not only was some or all of patient's prior answer adeq ately responsive, but that certain unspoken implications are derstood and eve agreed upon as a prerequisite to topical movement. Third, physicians employ "0 ays" as resources for managing turn-transitional environments involving simulta eous speaking and, at times, continuations by patient. In these circumstances, an not uncommonly so, physicians' "Okays" are embedded in the task of not direc y addressing patients' elaborated response, essentially disregarding and even ignoring topics raised by patient. Here it is seen that "Okays" make possible ph sicians' options for following up on a prior answer in a particular (clinically re vant) fashion, putting on hold one portion in favor of another topical issue, and at times altogether disattending what was projected and thus made available b patient in prior turn-at-talk. Of interest in these types of interactional moments are how physicians persevere in retaining the option of assessing the relevancy and/or lack thereof) of issues raised and concerns held by patients. Moreover, it was shown how physicians may simultaneously display acceptance *and* red tion of various contributions offered by patients, and in so doing preserving an utilizing what is interactionally constructed as an "institutional privilege" to s ectively address-even "shove off'-patients' matters while systematically mo ing toward what are put forth as clinically relevant concerns. And finally, altho gh patients appear to overwhelmingly and immediately align with and adhere t closures and openings initiated by physicians, there are moments where pati ts continue to speak and elaborate on selected issues. These more persistent co tinuations gave rise to physicians"'Okays-in-a-series" (and, at times, "Alhight"), clearly placed and repeatedly designed to bring such patient-initiated talk to a ose.

Taken as a wh e, the "Okays" evident within the cross-situational data summarized above pr vide only partial access to more encompassing, "doubly relevant" activities: p serving and constraining options, closing down and opening up topics, inviting nvolvements and enforcing focus, soliciting and protecting, accepting and rejecti g, checking understandings and making points. These kinds of activities consiste tly reveal the priorities and concerns of providers and clients, and thus an overw elmingly important and complex set of clinical problems: how it is.possible that 'official" clinical priorities get pursued in the face of lay persons' attempts to c structure interviews. It cannot be overlooked that it is patients who are seeking a sistance, just as it is readily apparent that clinicians take on the "authoritative" esponsibility for eliciting, regulating, and evaluating information. Understandin just how clinicians interactionally impose their institutional status, invoke ce in "privileges" in the course of guiding and directing these activities, and othe ise work toward achieving the business at hand is of practical consequence for p ctitioners and researchers alike.

Returning to th teaching-learning positions taken by Verby (1991) and addressed at the outs t of this chapter, it should now be clear that the kinds of activ-

ities within which "Okays" are embedded are considerably more diverse and complicated than clinicians have assumed. Although "Okays" have little if anything to do with "reinforcing some harmful behaviors" throughout interaction, they are implicated in a rather diverse set of interactional moments involving, for example, how or if patients' answers are treated as adequate or sufficient. And although it is certainly the case that "dictionaries" are not analytic replacements for detailed examinations of recordings and transcriptions, it is important to draw attention to the literal "meaning of a word" such as "Okay" versus the "situated and meaningful usage of an utterance" recruited to achieve a host of practical interactional tasks. Similarly, there is some truth to Verby's claim that "an ok response also conditions and prepares patients to wait for the doctor's next question." It is, after all, doctors who are consistently pursuing "official" business by relying on "Okay" as one resource for closing down, and even disattending or ignoring altogether, what patients may be contributing to the diagnostic interview.

Yet treating "Okay" as the "destructive" source of such actions, and assuming that problems arising from such behaviors might be eliminated altogether by exorcising "Okays" from clinicians' lexicon, is not a realistic solution. Rather, the attempted elimination of "Okays" is at best a "quick fix" or "band-aid approach" to more precise understandings of what is at stake given the overall focus, purpose, and procedural manipulation of these clinical activities: matters involving the interactional negotiation of "official" versus "lay" orientations, and their consequences, that requires ongoing and closer inspection.

In this light, it is not surprising that Verby reported the following:

> [by the] third or fourth month of the student-physician's stay, the use of ok has been eliminated by the majority of the students. However, in the last set of videotapings (done at the end of their rural Minnesota experience) a significant retention of the use of ok recurs in the majority of students. However, the intensity and quantity of oks have been significantly reduced. Whether the retention of oks persists or not depends on the student's attitude, behavior, and willingness to change interviewing idiosyncrasies. This change also requires strong support and reinforcement by knowledgeable and emphatic academic and clinical faculty over a long period of time. This would include surveillance into and through residency training.

Here the observation might be made that although "Okays" may be eliminated for a brief period of time, it is natural for them to seep back into clinical practice despite efforts to "change interviewing idiosyncrasies": "Okays" are simply yet deeply implicated in the "asymmetric" and proactive work of structuring interviews in pursuit of clinical agenda and goals, at times in consideration of but, seemingly, just as often at the expense of patients' elaborations, continuations, and related contributions. These and related actions often provide a basis for complaints and actual displays essentially treating doctors as inattentive, impatient, not listening well, and/or failing to appreciate and value the insights and stories of-

fered by patients cf. Heath, 1986; Jensen, 1987; Mishler, 1984). And notice that such complaints d reactions fall short of attributing malicious intentions to doctors; instead, descriptions of and visible orientations to real time interactional involvements are offered.

Clearly, then, until and unless the focus and priority of "official" clinical business is eliminated altogether, which of course is quite unrealistic given the inevitability and omnipresent features of professional-lay interactions (cf. Drew & Heritage, 1992), the reliance on "Okays" (and other resources) as recruited components for controlling and shaping topical progression will undoubtedly continue. This is so despite recommendations to the contrary by "knowledgeable and emphatic academic and clinical faculty" who, knowingly or not, may be creating additional rather than resolving present troubles: offering prescriptive solutions to recurring interactonal difficulties, the real-time specifications of which remain premature and largely underdeveloped.

It is on this basis, however, that clinicians and academicians can mutually benefit from one another's experiences, insights, and findings. Although this chapter began by considering one case study involving "Okays" drawn from the RPAP program at the University of Minnesota Medical School, and through analysis generated alternative and at times competing findings, it is nevertheless laudatory that this program and many others turn directly to videotaping interviews for purposes of better understanding and refining interview techniques. Yet when such difficulties exist with understanding the interactional usages and ramifications of "Okays," which after all reveal only one small, although no less consequential range of phenomena when considering the larger scheme of activities through which talk-in-interaction gets practically accomplished, it takes little imagination to realize the problems inherent in making yet "larger" claims about the organization of casual and institutional conduct (cf. Beach & Lindstrom, 1992; Drew & Heritage, 1992; Schegloff, 1987b;).[6] And especially for clinicians, these troubles hold the potential of becoming exacerbated when attempting to prescribe and thereby alter behaviors that have not been fully and contextually examined "by reference to their placement and participation within sequences of actions ... to its turn-within-sequence character" (Atkinson & Heritage, 1984, pp. 7, 9).

And it is in this sense that the fact remains, and is clearly evidenced via "Okays" and the activities trey are recruited to achieve within medical interviews, that premature movement to prescription is problematic: so doing is tantamount to generating a diagnosis prior to understanding the symptomatic nature of an entire range of problems, emerging from and uniquely situated within a fully disclosed medical history.

°It is in the concern with "big issues" that Sacks' (1984) basic focus rested with the organization of human interaction, and consequently how such entities as "institutions" exist only through members' concerted activities:

> The search for good problems by reference to known big issues will have large-scale, massive institutions as the apparatus by which order is generated and by a study of which order will be found ... It is possible that detailed study of small phenomena may give an enormous understanding of the way humans do things and the kinds of objects they use to construct and order their affairs. (pp. 22, 24)

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