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
interviews with patients, the sense of how to phrase "questions" and "answers" becomes reified by clinicians, thus setting the stage for sustained focus on how specific discourse "to do" and otherwise control the initiation and elaboration of "next question" to selectively determine what or if some portion of a prior answer is adequate, which may or not be foundational to the underlying clinical focus of an interview.

As becomes evident, the very fact that it is physicians who overwhelmingly emote "Okays" in clinical settings, in the vast majority of cases, what has become a well recognized set of clinical practices (cf. Drew & Heritage, 1992; Markova & Foppa, 1991) reflects various realms of social interaction involving relations between institutional persons: Given the predominance of questions and answers, "prefaced" questions, cf. Heritage & Sorjonen (in press); 1991), institutional incumbents routinely engage in such activity as "next question" to selectively determine what or if some portion counts as an adequate response, what issues may or not be particularly in medical interviews) even whether or for what pericases will be talked about (cf. Byrne & Long, 1976; Ge & Greatbatch, 1991; Mishler, 1984; Silverman, 1987).

These and related contingencies are apparent in the interactions examined here, reflecting varying degrees of difficulties—little or no trouble 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. 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 inter- actionally 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...
family members as actual and/or roles with trained an repeated observations and slow-motion re
don to a wide variety of by-case basis, ensue effective interviewings or otherwise negative, priority. As noted, ine interactional behaviornships constrat
The reliance on novative and indiscommunication inveals the details of interal events (and, whe
Yet there are inhily remedied. In pra
may be stated as fonal organization
Numerous issues for prematurely disunication. Consider, first materials under inv
titate the basic e sorts essentially am he first instance by ily's inspection, a
What resources werings were displayed ached actions, and j enfolding character
Second, these an my given interactiono, i.e., in the first instures of such actio medial interview tmon descriptions ematic. The move t he more troubling.
rove clinical practi certain behaviors w ell. Basic procedures are relatively straightforward: Follow-
playing medical interviews, participants review their record-
oped 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 techniques. Similarly, the identification and elimination of more or less dysfunctional behaviors or patterns is also a top p e overriding concern, and understandably so, is to minimize i
rs leading to problematic understandings and conflicting re
ng positive healing outcomes.
irected, interactionally grounded review sessions is both in-
nsible 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-
ppropriate, transcriptions as well).
tent 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-
prove-patient encounters on their own merits?
underly why such difficulties should neither be overlooked unted as untrustingly 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-
stance of some interactional "phenomenon." Such work ef-un 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 understanda 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 c e), 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 pro-
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 discernments? By what criteria are such critical judgments made, reasoned, and subsequently imple-
ented into clinical practice? What are the practical consequences of "pre-
scribing" 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 dan-
ber can be put on hold, however momentarily, by considering one set of conclu-
sions (generated by physicians) regarding "okay" usages in medical diagnostic in-
views, 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 Pro-
gram (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 stu-
dents as a means of grounding and thus facilitating their medical education in prac-
tical situations of choice and action. Videotaping and reviews (lasting from 1 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 explana-
tion to the student physician.
As evidence for these dysfunctional claims of "Ok," and corollary attempts to elevate usages in inerviews, Verby provided the following "typical scenario" (S = student; PJ = patient 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:  "Ah, about a six-pack of beer."
S:  "Ok. What about tobacco?"
PJ:  "About two packs a day."
S:  "Ok. How long?"
PJ:  "About twenty-five years."
S:  "Ok. No I want to ask you about drugs."

- readers are not explicitly informed that this is a transcription of an actual inerview, 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, typied:
- a general, reconstructed instance invoked by Verby to provide sufficient evidence of claims offered ed (i.e., that "This style of questioning ordinarily continues throughout the interview").

From these data it may be useful to consider five sets of issues emerging from ise 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 everyday casual conversations and across a wide variety of institutional interactions (cf. Beach, 1993a; Jensen, 1987), they are frequently used and relied on, althoug almost exclusively by medical authorities and only in specific cases by atients (as apparent! following sections). Yet just how frequently they are employed, and in what kinds of interactional environments, raises a surprisingly complex 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 inferring each patient response. Following Exemplar 1, it would be easy to conclude that "okays" are nearly mandatory prefaces to physicians' next questions c., "Okay-preface questions"). And although this is by no means the case in aturally occurring inerviews, the frequency and apparent foci of "Okay" usages are revealing when determining what is "at stake" in speech exchange comprising discursive medical interactions.

2. Webster's Dictionary defines "Okay" as "approval or endorsement," thus sages in interviews are "inappropriate ... [destructive] as a response ... inaertently 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 conceptualphilosophical 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 video-recordings 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 works. 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 interactionally 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 prove 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."

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 information 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 to "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")

S: "Ok. What about tobacco?"

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

S: "Ok. Now I want to ask you about drugs."

PJ: "About two packs a day."

S: "Ok. For how long?"

PJ: "About twenty-five years."

S: "Ok. For how long?"

PJ: "Ok. Now I want to ask you about drugs."

1-~

S: "Ok. What about tobacco?"

3-a

S: "Ok. Now I want to ask you about drugs."

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")

S: "Ok. Now I want to ask you about drugs."

to which PJ 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 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 apparent 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 surface, therefore, these two claims appear minimally as underdeveloped and, perhaps, contradictory to the very work of "approving and accepting" attributed by Verby and discussed previously: if patients treat doctor's (student's) "ok responses" 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 inaccurate claim), then why is it more difficult to "obtain necessary personal information?"

At least one reasonable answer could be generated to such a query, en route to describing and examining certain "hypothetical" consequences noted by Verby. On one hand, patient orienting to "ok responses" as doctor's attempts to "condition/prepare" patients' 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 attempts to constrain, regulate, and otherwise close-down patient-initiated actions. Over the course of an interview one consequence may be eventual and purposive withholdings by patients, making providers' work of eliciting patients' disclosures increasingly difficult. Another involves elaborated speaking and thus continue bids for the floor by patients; a basic display of unwillingness to refrain from talking 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" placements 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 problems in establishing, coordinating, and maintaining mutual involvements in professional-client interactions. Heath (1984, 1986, 1992), for example, has amply demonstrated how both speakers and recipients rely on vocal and nonvocal resources (e.g., gaze, gesture, postural shifts, kicks) as recruited components for particular courses of action, including the work of eliciting another's attention and response. Similarly, Frankel (1990) identified various ways in which physicians display dispreference for patient-initiated questions, impacting how patients design their talk in ways sensitive to speaker's rights and obligations in medical encounters (i.e., interactional constraints shaping the unfolding character of 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 the kinds of troubles as when speakers telling a trouble receive displays lacking ignominy and/or affiliation from recipients (cf. Beach, 1993b; Drew & Holt, 198; 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
It is not uncommon, particularly in medical diagnostic interviews, for topic shifts to be eyed without a hitch. The basic three-part sequence described earlier as involve g "third turn receipts" and comprised of "Question - Answer - Question/topic shift," is easily recognizable:

<table>
<thead>
<tr>
<th>Exemplar 1 (Street 2:5:4; arrow mine)</th>
<th>Dr:</th>
<th>When did you first start having your periods (0.2) &quot;how old were you&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>P:</td>
<td>Think I was thirteen</td>
<td></td>
</tr>
<tr>
<td>Dr:</td>
<td>&quot;Okay&quot; an when did they get regular</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exemplar 10 (Street 2:5:5; arrow mine)</th>
<th>Dr:</th>
<th>How many days in between yer periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>P:</td>
<td>&quot;Oh probably&quot; (1.4) they usually last four days</td>
<td></td>
</tr>
<tr>
<td>Dr:</td>
<td>&quot;Kay&quot; ya have a heavy flow?</td>
<td></td>
</tr>
</tbody>
</table>

In both exemplars, the doctor treats the patient as having been responsive to the question (or as in Exemplar 9, two questions), adequately answering and understanding being solicited. In third turn the doctors' "Okay"/"Kay" display such orientations while also making way for next-positioned responsive to neverthlessness. This appears the case even in Exemplar 10, where P's answer is not directly qualified and adequate "yes" (i.e., "always regular" -4 ever since I had my last baby"), thereby reducing the ambiguity arising from Dr's first question and P's initial response (cf. Schegloff, 1984). Once achieved, momentary topic shift is the initiated via "okay now you're seventeen." And as responsive to P's unequivocal, "Mm hm," Dr's (3-+) once again receipts with "Okay + [next (prefaced) question/topic shift]," an activity re-establishing prior focus on symptoms of the presenting complaint ("periods") with a related medical problem ("bleedin").

In Exemplar 11, then, Dr's refocusing in (3-+) emerged as a consequence of prior work designed to insure that sufficient understandings had been obtained. In the following partial repeats in (1-+ and 2-) that Dr moves next to confirm P's age and, once completed, to move "back" yet "onto" next official matter-generating a history of events assumed to have direct relevance to the presenting complaint of "abdominal contractions and pains." In this environment, Dr's "Okays" added closure to understandings now refined, and in these ways remedied, via repeated clarification and confirmation; they also made possible the decided shift back/onto matters deemed relevant by Dr. In so doing, Dr preserved the opportunity to treat a particular answer as insufficient, remedy the problem in satisfactory fashion, and then (but only then) re-initiate a trajectory of questions addressing 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 repeats to seek clarification and display confirmation of prior answer provided by I. Within these environments, "Okays" are recruited by Dr to display that some all portions of P's answers are not only adequately responsive, but that certain unspoken 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, however, they do not always preface immediate topical shift and forward movement (e.g
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)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C:</td>
<td>(O)Kay (whispered)</td>
</tr>
<tr>
<td>D:</td>
<td>Alright</td>
</tr>
<tr>
<td></td>
<td>this time to:: compressed (0.5) get your- (0.6) take the pressure off yourself ok?</td>
</tr>
<tr>
<td></td>
<td>C:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Three observations might be made regarding "Okay" usages in this instance. First, in (1-4) the therapist relies on a tag positioned, upward intoned "ok?" which is quietly received ((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 oky?". 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 "Alright + [We'll see you o:n (. ) Tuesday" ("Alright" 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 ng movement from "diagnosis" to "physical examination":

Although Jensen (1987) proposed an "apparent equivalency" between "okays" ait "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 associ ated with medical authorities), and more with what approaches but is not qui "granting D permission" for a physical examination (which is nevertheless e xpected 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 ather.
predominant y cede not only (as well as corn is your arthritis though such "Y was projecting some next matt from a topic in pp. 27-28) - ever trajectory current speaker.

Attempts to Schiffrin, 1987) course markers episodic bound endings, and/or including facili (cf. Sinclair & however, is writings: Jensen's terviews (across marking beginn intimates, atte "pacing and pun question-anse vidual questions of topically rel lengths.

One key con in a larger colle overviewing an comparisons with minimized acknowledgment token, "Yea"s commonly preshifts in topic but also such actions as brief assessments entaries leading to such shifts (e.g., "Ygh that's goa.d. u-How you still taking ahoas?"; Jefferson, 1993, p. 10). However, al-ahs" repeatedly come off as exhibiting attention to what speaker in prior utterance, and doing so in the very course of shifting to rs, it is also a clear display of a "recipient working to disengage ogress in order to introduce some other matters" (Jefferson, 1993, ors toward topic attrition in attempting to bring to a close what topical line is being pursued, thus underway and in progress, by understand these kinds of topical activities (cf. Redeker, 1990; also emerged from classifications of "okays", among other dis-particles e.g., well, now, so), as devices employed to manage es and to bracket defining units of talk: for example, beginnings, ore subtle movements toward topic shift (cf. Goffman, 1981), ting the "cadence and pulsing activity" of various classroom tasks outldard, 1975). Of particular relevance to the ensuing analysis, t appears to be the only inspection of "okays" in clinical set-1987) examination of "Okays" in 12 diagnostic medical in-six physicians). Describing "Okays" as "bracketing devices" gs and endings of tasks in the specialized context of diagnostic on was given to how "Okays" reflect physicians' techniques for tuating" (p. 53) interviews by their placements within and across sequences; "Okays" were found to routinely separate both indi-and answers, and in other cases mark boundaries among clusters led questions comprising interactional segments of varying

In Exemplar 5, D brings to a close the work of getting situated for the interview 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 creating a medical record of the event. Once completed, D then relies on "ok" in transition to the official business-"what can I do ya hhh. ( )what's happenin="- two separate, although related queries, the first revealing D's recognition that the patient has a medical reason for visiting, which D can hopefully assist with, the 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 exemplar 11). In Exemplar 12 Dr's "Okay"-prefaced query in (1-4) emerges, and, d days so, as a consequence of both P's prior answer to the original question ("Yes ma'am") and the subsequent explanation offered by P ("but u:h ... "). This tance essentially partitions the two components of P's answer and handles each differently:

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

Dr: Did you realize at that time that you had hurt yourself?
Yes ma'am but u:h (0.6) I still had Iwo hours before I was off
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 hurt after > (0.2) the accident

In (1-4) a deci
Okay" treats P and thus constrains P's answer to be incomplete, as a replacement for its further elaboration by P (commentary that at this point remains readily apparent with P's "So" in (2-+). Next, in lieu of and thus for P's talking, Dr's "so you went ahead and worked?" addressed yet unspoken in P's prior elaboration. Of interest here is how use of what P may very well have specified had Dr not moved to talking by P. Notice, for example, the overlapping and simulta-
neous producti
in placed immediate closure and ob-
stance completi-
"Yes ma'

Dr's query (1-4) can now be seen and understood as an effective substitu-
tion for the v
vice for pre-em-
swer has been o-
ated a part of two unequivocal kind of minimal answer from P. And having now received answers from P, Dr is in a position (in 4-p) to shift and move for-
offic" business involving what P noticed that "hurt after (0.2) position generated and preserved by not just constraining P's op-
but also soliciting from P what Dr treats as a suitable response, possible forward movement in the interview.

There is also a hint of another emergent problem in Exemplar 12; (see also Ex-emplars 13-16) involving P's overlapped "So," namely, simultaneous and overlapped speaking by both Dr and P. In this instance the problem of determinin-
who is to speak, for how long, and on what topic is immediately resolved due to both P's discontinued speaking and (in 4-4) Dr's movement to the next question. Yet this fleeting moment is nevertheless reflective of the collaborative work nec-
soary between Dr and P in jointly managing floor access and, ultimately, ways in which topics get raised, elaborated upon and/or brought to a close (and, of course, by whom).

In Exemplar 13, for example, Dr and P are addressing P's recent and painfult 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
P: Hoping it would get better because you know I have to work (1.2)

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 be-
ning speaking at the next turn-slot: Dr begins to ask a follow-up question precisely when P elaborates by qualifying prior "Yeah" answer-a continuation that repeat:
Dr's initial query by first correcting and replacing "thinking" with "Hoping..."
[explanation regarding work]. Here P's "Yeah" is responsive to Dr's prior query and does, at 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 of some importance: one form of reason-giving that could be tempt to solicit Dr's understanding, perhaps even commiseration, redicament. For example, P's "you know" specifically addresses invites Dr to become a coparticipant, one who at least acknowledgments P is facing. (Chapter 10, this volume addresses this issue.)

Notice, ho recycle and elaborated as an acknowledged P's introduce Dr engages in giving as Buff route to shift and even igno take, and thus elaboration, about the app jury occurred.

And just h overlooked. which two rim particularly in actually colla had, only mo disclaiming is very actions D into Dr's discl giving and sol.

For these r Ka::y," should be Dr begins by disclaiming knowledge about "cars," throughly and practical activities are achieved. First, Dr's disclaiming is a provocative (although indirect) method for inviting P to assist Dr and rate in shifting away from (and thus essentially avoiding) what P's answers before, put forth as issues of some importance. Second, Dr's itself a form of reason-giving amounting to a justification for the has initiated. Viewed together, the inviting and reason-giving built presenting offers a uniquely tailored response to P's own prior reason-giving amounting to what P's treatment for chronic back pain.

Turn-Transiti nal Environments

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

less) competitive and continuous (cf. Beach, 1993a), "Okay" usages may app 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 environments 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 continues 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)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| S= significant other 
D= Dr  |
| P= patient |

1-a S: = [ ] he had planned to th is w eek 
2- P: = he had 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 ( ) 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 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, this 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 background 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 actively avoiding further elaboration upon topics implied in P's background, ensuring that "tests" be addressed as efficiently and sufficiently again, not coincidentally, on the doctor's own terms.

It is in this way that D's closing "ok" in (4-4) is every bit as much a rejection topic nomination as an acceptance of the sufficiency of P's report to say that clinicians do no rely upon "Okays" for straightforwardness of some prior response. But (Exemplar 14 4-3) does not appear as, little or no acceptance per se is displayed by D. In terms of shift topics via as an "interjekt"-not unlike P's (2-a), in Exemplar 14, described earlier de deletion-Jensen (1987) began to address how patients may continue speaking 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 . hum::: ( ) do you have asthma

Put simply, speakers to whom "Okays" are addressed may themselves disattend attempts with continuation, creating points of negotiation over boundary issues. Yet it is important to stress that in Exemplar 15, other data provided by Jensen (1987) as evidence of these claims, and further medical diagnostic problems, have not been found where patients absolutely refuse to adhere to doctors' attempts to shift topics toward what they prioritize as more important and relevant "official" matters (i.e., when accomplishing such problematic questions of (a) determining whether "displaying acceptance" and as sufficient" are functionally equivalent descriptions, and (b) whether orienting oneself" is functionally equivalent to such actions as "closing down, disattending, pon" and similar ways of perceiving the work of some next speaker's way of making what prior speaker's turn-at-talk. Although an extensive discussion of these implications for understanding both casual and institutional interactions would be useful, it rests be

This raises the to prior turn as "su failing to elaborate managing options a issues, and their dividing be useful, it rests be tasks as "revealing a medical history," "creating a medical record," "retrieving facts for necessary for diagnosis," and so on.) And although Bergmann's (1992 analysis of psychiatric intake interviews has revealed several kinds of "explosive 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 case with the medical interviews examined for this chapter.

By reinspecting Exemplars 14 and 15, several common features become noticeable: (a) P is caught up in producing a fuller description than D may have "preferred"; (b) at transitional/opportunity spaces, D relies on "Okay" in ways treated by P (via continuation) as premature movement to closure; (c) yet in orientation to 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 to 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 Exemplar 15), P does terminate speaking, giving rise to D's (2-)"OK" repeat + [topic shift 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 clear 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 tinuously (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 to deal with some interactional trouble (e.g., attempting to terminate another's continuation in order to get back on track), and also to terminate what are themselves: treated as particularly troubling topics or activities. Across such usages, the rull of thumb appears to be the more "Okay" usages, the greater the trouble requirin 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 D: a ha=
P: =or slept next to em in jail

3 D: ok ( ) ha ha yes::
   [ ] I [ ] I
   =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 tri-marked 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--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 "Okay" 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 if, portant that, apparently, patient-initiated actions such as continuations, indirect answers to questions, and unsolicited comments can essentially "sidetrack" ([Beach, 1990a, 1994). Simply put, on such occasions it is not uncommon for clinicians to rely on "Okays" as devices variously designed to constrain clients' talk and allow subsequent queries attempt to bring talk back in line with particular topics 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 more or less contrasting sets of relevancies and priorities throughout discursive interactions, in the vast majority of cases it is physicians who proactively reckon "Okays." Generally speaking, in the course of guiding and directing topics and activities; seeking clarification and enhanced understandings as apparent prerequisites to topic shift; simultaneously constraining patients' options while preserving physicians' abilities to initiate topic shifts by focusing on specific kinds of actions and priorities. As interactional resources physicians routinely rely on "Okays" are especially employed as partial solutions to ongoing problems, particularly those treated as distracting to, or even momentarily in competition with what "institutional authorities" are working toward in carrying out role-incumbent 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 receipt of what was taken to be meaningful in P's elaborated utterance, the opportunity to assess what and how an utterance (and portions thereof) is deemed relevant 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 "officially" matter.

Strikingly similar findings are beginning to be generated across a larger corpus of institutional data, including more diverse clinical involvements (including family, 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 reflect emergent, altogether institutional, contingencies.

The diversity of "Okay" usages across the medical diagnostic interviews exam ined 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 troubles requiring remedy on the other. First, physicians may simply treat patients (v "Okay" as third turn receipt) as having been adequately responsive in prior ansy to initial question. Second, "Okays" may precede partial repeats and/or dire
queries seeking clarification and confirmation of patient's prior answer. In these circumstances, "Okays" may also display that not only was some or all of patient's question not immediately responsive, but that certain unspoken implications are understood and even expected. In cases involving simultaneous tasking of not direct action and even making possible phrasing (clinically relevant topical issue, and made available by means of an actional moment), interactional negotiation of the relevancy of the patient's utterance is not uncommonly so. Physicians' "Okays" are embedded in the process of addressing patients' elaborated response, essentially disregarding topics raised by patient. Here it is seen that "Okays" function as options for following up on a prior answer in a participating fashion, putting on hold one portion in favor of another at times altogether disattending what was projected and thus patient in prior turn-at-talk. Of interest in these types of interactions is how physicians persevere in retaining the option of assessing and/or lack thereof) of issues raised and concerns held by patient. It was shown how physicians may simultaneously display their understanding and concerns held by patient, and in so doing, what is interactionally constructed as an "institutionally effective" turn-taking practice even "shove off" patients' matters while interacting toward what are put forth as clinically relevant concerns. When patients appear to overwhelmingly and immediately align closures and openings initiated by physicians, there are attempts to continue to speak and elaborate on selected issues. These attempts gave rise to physicians' "Okays-in-a-series" (and, at times, "Alright"), initiated talk to a new "reset" state, the "Okays" evident within the cross-situational data summarize only partial access to more encompassing, "doubly reinforcing" and constraining options, closing down and opening involvements and enforcing focus, soliciting and protecting, according, checking understandings and making points. These kinds of actions more precisely address -even "shove off" patients' matters while interacting toward what are put forth as clinically relevant concerns. It is not surprising that Verby reported the following:

"Okays" in the use of ok have 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 empathic 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, impatients, not listening well, and/or failing to appreciate and value the insights and stories of
ferred by patients cf. Heath, 1986; Jensen, 1987; Mishler, 1984). And notice that such complaints of 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 interactional 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 conventional and institutional conduct (cf. Beach & Lindstrom, 1992; Drew & Heritage, 1992; Schegloff, 1987b). 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 they 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.

**REFERENCES**


Beach, W. A. (1994). "Okays" and their relevance to "making points" in therapy and counseling sessions. Unpublished manuscript.


M. Atkinson & J. Heritage (Eds.), *PRESERVING AND CONSTRAINING OPTIONS* (pp. 28-52). London: Cambridge University Press.


