

## Reappraising Garfinkel's notion of "self-organizing" setting

### An example of negotiation over treatment at a mental clinic

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#### 1 Introduction

In his seminal book *Studies in Ethnomethodology*, Harold Garfinkel recommended seeing any social setting as "self-organizing with respect to the intelligible character of its own appearances as either representations of or as evidences-of-a-social-order." (Garfinkel 1967: 33) The aim of this presentation is to demonstrate the significance of the notion of "self-organizing" setting to sociology in general and to studies of social interaction in particular.

In traditional sociology, actual social interactions have been paid little attention except as "effects" of so-called "trans-situational" social facts (e.g. social structure, institution, class, status, power, etc.). Erving Goffman challenged such neglect of interaction and proposed that interaction order was worth studying in its own right, not by connecting interactional appearances to "trans-situational" social facts behind them, but by seeing syntactical relationships among appearances. He was not clear enough, however, as to how the "trans-situational" social facts are related to the interaction order. He didn't go further than suggesting that they are "geared into" interactional appearances in accordance with some "transformation rules" (Goffman 1961).

Garfinkel's recommendation enabled us to have a radically new view of the matter. By considering how appearances are intelligible to the participants in the first place, he found *methodical* character of practical actions. Practical actions are produced as solutions to practical problems faced in contingencies in a particular setting. Because participants take for granted, rely upon and exploit intelligible character of the setting in solving the problems, the ways they perform practical actions exhibit their orientation to the setting and thus make it available to each other as contexts for their interactions. From this viewpoint, "trans-situational" social facts can also be looked at as to how they are intelligible to the participants themselves. They can be seen as made intelligible and realized to the participants by the ways they perform practical actions. In this respect, they are methodically organized as a part of self-organizing setting.

To demonstrate the significance of such a view, I take as my material a negotiation over treatment in a consultation at a mental clinic. I examine how such a "trans-situational" social fact as 'asymmetrical entitlement between a professional and a layman' is realized and unrealized as a part of the setting, through the ways the participants solve practical problems faced in the negotiation over treatment.

#### 2 Treatment recommendation and resistance

This consultation took place between a female doctor and a male patient at a mental clinic. He first visited the clinic in March and was diagnosed with "anxiety disorder." The consultation under focus was his seventh consultation in May.

After exchanging greetings, the doctor asks the patient how he is feeling. He answers by telling a story. He had gone drinking about two days ago, had drunk quite a bit, and so had skipped taking medicine that night; he woke up late at night, vomitted and felt anxious; the next morning he woke up to find he was really down; and since then he has been down. Then the doctor asks how much he drank and gets an

answer. While she is writing on the patient's chart after that, the patient adds that he can't help thinking this might be depression or he might suffer from hyperventilation, and completes his problem presentation by saying that he "is wondering how he can think positive". The doctor withholds addressing this possible request for advice and just receives it as a piece of information. The excerpt (1) starts after that.

(1)

01 D: ↑ima okusuri wa:: sonotoki wa:: ototoi wa nomanakatta >kedo<  
You said you didn't take medicine then, the day before yesterday, but

02 a:to wa zutto nonde ru:?  
have you been taking it since then?

03 (0.6)

04 P: >soo desu ne hai nonde masu [hai<.  
Yes, I have, [yes.

05 D: [hu::n  
[Mm.

06 (1.4) ((D turns from the patient to the PC. She keeps this posture until the end of this excerpt))

-> 07 D: °>Pakishiru o<° mo::o chotto huyashita hoo ga ii kamo ne.  
Perhaps a little higher dosage of Paxil might be better.

08 (0.7)

-> 09 D: ↑mada antee shite nai mon ↑ne.  
'Cause you're still not in stable condition.

10 (0.4)

=> 11 P: .hhhh a: soo desu ka.  
.hhhh Mm, really?

12 (0.2)

13 D: n:n  
Yeah.

In line 01-02, the doctor asks about the patient's regularity of taking his medicine. The patient answers to it in line 04 and the doctor receives the answer in line 05. The doctor turns her body from the patient to her PC on the right (line 06), and then evaluates efficacy of a little higher dosage, which is hearable as a

treatment recommendation (line 07). After 0.7 seconds of silence, she adds to it an evaluation of the patient's condition as a reason for the recommendation while keeps looking at her PC (line 09). At this point, the patient responds to it with an information-receipt (line 11), which is the focus of this section.

The doctor's utterance in line 07 ("Perhaps a little higher dosage of Paxil might be better.") may be ambiguous in its sequential implicativeness. Though a positive evaluation of a treatment is hearable as a recommendation, she produces it with a display of uncertainty ("*kamō*") and by turning away from the patient and checking his clinical record on her PC. She may be hearable as 'thinking aloud', so to speak, and as having not yet produced a final recommendation to the patient. However, as she offers further evaluation in line 09 ("Cause you're still not in stable condition."), she retrospectively makes clear that she is recommending the treatment and the patient's agreement/disagreement is relevant. By designing it as a reason for the previous evaluation, she is removing a possible obstacle to respond and thus pursuing response.

Note that the evaluation of a patient's condition can be either an entitled action of a medical professional or an action open to a layman, depending on the way it is produced. Here, it is produced as an action open to the patient with the use of a resource for seeking agreement ("*ne*"). In other words, the doctor produces it in such a way as to minimize the asymmetry of entitlement between a professional and a layman. Though a medical consultation is an encounter between a professional and a layman, whether and how such "trans-situational" identities are realized is displayed in the way practical activities are performed.

In light of such observations, the patient can be seen as withholding agreement in line 10-11, and through it, resisting the treatment recommendation. By responding with an information-receipt ("Mm, really?"), he rejects the supposed accessibility and displays his understanding that the doctor has given him a professional evaluation. Given that the treatment has been recommended in a way that minimizes the asymmetrical entitlement, a way of responding that emphasizes the asymmetry can be used to resist the recommendation. An information-receipt is available as a resource for recognizable resistance in that it exhibits his orientation to the asymmetrical entitlement. This illustrates that "trans-situational" identities are organized as a part of the setting by the way practical actions are methodically produced.

In studies of doctor-patient relationships, the asymmetrical entitlement has often been pointed out as suppressing a patient's wish (Freidson 1970; Heritage 2005). However, the patient in this case exploits the asymmetry to resist the doctor's recommendation. By such exploitation, he can here achieve resistance without being "accountable" (Sacks 1992) for it. An overt disagreement to a doctor's evaluation of the patient's condition might be regarded as accountable in that it might implicate a challenge to the doctor. The patient can avoid such accountability by responding to it with an information-receipt. In the next section, I will turn to a later part of this negotiation to see how the doctor counters to this way of resistance and how the patient responds to it.

### 3 Reversal of accountability

After the excerpt (1), the doctor pursues agreement by providing the patient with relevant medical information that may support her claim that a higher dosage is better than what the patient seems to wish, continuing on his current dosage and trying to think positive. Ironically, however, it is exactly such informing of medical knowledge that can be properly responded to by an information-receipt (e.g. See line 92-94 below). Given such power of an information-receipt, it is not surprising that a counter-resource is available to a doctor in such a negotiation.

(2)

92 D: ima no jiten dewa (0.8) chotto (0.9)

At the moment, (0.8) a bit (0.9)

93 moo sukoshi zooryoo ga hituyoo ka na: tto ° omoi masu (kedo).°

a little higher dosage may be necessary, I think.

94 P: .hhh a: soo desu ka.

.hhh Mm, really?.

95 D: nn

Yeah.

96 (2.8)

97 P: °.hhhh nn nn°

°.hhhh Mm mm°

-> 98 D: >tatoeba< (0.3) nijuu ni shite::,

For example, (0.3) if you stayed at 20 milligrams,

99 P: hai

Uh huh.

-> 100 D: mochiron (.) kimochi no mochi yoo de tte yuu koto de de↑kireba ne: ,

and if you could think positive,

101 P: hai.

Uh huh.

102 (0.2)

-> 103 D: i n da kedo: ,

then it would be all right, but

104 (1.0)

-> 105 D: sonnna:- anmari:- ano:: (1.2) muzukashii yo ne. soo yuu no tte ne.=

that- not so- y'know (1.2) it's difficult, isn't it? to do something like that? =

-> 106 =[kimochi no] mochi yoo de toka tte ° (yuu no wa).°

= [to think ] positive?

107 P: [ .hhhh ]  
[ .hhhh ]

=> 108 P: maa so::o desu yo [ne:.= tada]:: kusuri ga agaru tte yuu koto [de::,  
Well, maybe you're ri|ght. = but ], when I think of a higher dosage,

109 D: [nn ] [ ° n n °  
[ Yeah ] [ ° Uh huh °

110 (1.3)

=> 111 P: yokee fuan ni nacchau tokoro ari masu ne:.  
I become all the more discouraged.

112 D: hu:::~:~:n.  
Do you.

After the pursuit of agreement is resisted by another information-receipt in line 94, the doctor designs her next utterance as a request for confirmation (line 98, 100, 103, 105, 106). She begins by framing the utterance as a hypothetical concession to the solution the patient presumably wishes (“For example, (0.3) if you stayed at 20 milligrams, and if you could think positive, then it would be all right, but”), and then asks for confirmation of her assertion that the solution would be difficult to accomplish (“it’s difficult, isn’t it? to do something like that? to think positive?”). By asking for confirmation from the patient, she exhibits her orientation to a shared entitlement, rather than to the asymmetrical entitlement between a professional and a layman. The utterance cannot be properly responded to with an information-receipt and makes confirmation/disconfirmation relevant, and then if the patient confirms it, his resistance becomes accountable. By displaying that she is not oriented to the asymmetrical entitlement, she counters the patient’s way of resisting the recommendation, and pressures him either to agree with it or to account for his resistance.

The patient responds with the use of two utterance units (line 108, 111). The first unit makes a reluctant confirmation (“Well, maybe you’re right”). At its possible completion, where the doctor makes a confirmation of the confirmation in overlap (“Yeah.”), the patient immediately goes on to add another unit which qualifies his confirmation (“but, when I think of a higher dosage, I become all the more discouraged”). Though the patient is again recognizably resisting the recommendation, the way he does so here is quite different from what he did in the excerpt (1) and in line 94. By announcing his emotional experience, he is accounting for his resistance in a way that exhibits his orientation to “entitlement to his own experience” (Sacks 1992). Since such entitlement is independent from the asymmetrical entitlement between a professional and a layman, this way of resisting also doesn’t implicate a challenge to the doctor.

His resistance is now retrospectively accounted for as a manifestation of his very problem, the uncontrollable anxiety, rather than the effect of his insufficient understanding of why the recommended treatment is better. The doctor receives the account as a piece of information (line 112) and thus exhibits her orientation to the patient’s entitlement to experience. After the excerpt (2), she starts rethinking her recommendation and then proposes to continue with his current dosage.

Though the methods the patient uses to resist the recommendation are different in each excerpt, both of

them are produced as solutions to the practical problem of how to resist the doctor's recommendation without being heard as challenging.

#### 4 Conclusion

I have demonstrated that whether and how such a "trans-situational" social fact as 'asymmetrical entitlement between a professional and a layman' is realized depends on the local contingencies in the interaction; that it is realized and unrealized as a part of the setting through the way participants solve practical problems they face in those contingencies; that it is organized as a part of self-organization of the setting.

In mainstream sociology, patients' resistance to doctors' treatment recommendations and doctors' concessions to the patients may be explained by appealing to such "trans-situational" variables as the doctor's authority, difference in status between the doctor and patient, cultural difference between the two, and so on. Though such explanations may be useful to give a rough picture to observable patterns of behavior, they can't illuminate, inter alia, how the same participants with the same combination of variables use different methods at different points in interaction. In other words, such sociological explanations would easily miss how actual settings and practical actions in them are organized by and for the participants themselves. It is in such context that Garfinkel's recommendation continues to be valid in sociology, and especially, in studies of social interaction.

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