Not just ‘doctors’ orders’: directive–response sequences in patients’ visits to women and men physicians

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ABSTRACT. In this paper, I draw on Goodwin’s (1980, 1988, in press) research on directive–response speech sequences to examine how physicians formulate their directives to patients and how patients respond to those directives. My analysis of encounters between patients and family physicians indicates that women and men physicians issue their directives in dramatically different ways, and that their alternative formulations have consequences for patients’ responses. Some directives are more likely than others to elicit compliant responses, and women physicians employ these more often than men do. In discussing these results, I consider their relationship to the issue of patient adherence more generally and to the quality of patients’ relationships with women and men physicians.

KEY WORDS: medical discourse, conversation analysis, speech acts, directives, doctors, physicians, patients, women, men

INTRODUCTION

Doctors’ Orders. This phrase, used to describe a physician’s recommendations to a patient, implies that the patient has no choice but to do whatever is told (Shapiro, 1978: 170).

One of the most prevalent complaints in the literature on physician–patient communication concerns patients’ failures to do as they are told (e.g. Becker and Maiman, 1975; Davis, 1966; 1968; DiMatteo and DiNicola, 1982; Francis et al., 1969; Kirscht and Rosenstock, 1977; Steele et al., 1985). Estimates suggest that 20–80 percent of patients do not follow their physicians’ directives (DiMatteo and DiNicola, 1982; Sackett and Snow, 1979) and that, on average, one patient out of two does not do so (Ley, 1983). To the extent that physicians issue their directives in the interests of patients’ health, one can understand why patients’ failures to follow them would be deeply disturbing.

Despite this concern, the formulation of physicians’ directives to patients has not been pursued as an object of investigation. As Frankel and Beckman (1989b) point out, the problem of non-adherence has traditionally been seen as a function of patients’ lack of education or motivation, or as a function of...
physicians' failures to persuade patients of treatment benefits:

Until very recently, little if any attention was paid to the sequences of interaction that transpire whenever a practitioner and patient meet face to face, and the possibility that non-adherence might be linked to the dynamics of speech exchange (Frankel and Beckman, 1989b: 63).

As a result, we know very little about how physicians formulate their directives to patients or how patients respond to them.

And yet, a growing number of studies suggest that the dynamics of speech exchange are central to our understanding of physician-patient relations. For example, Maynard (in press) reports that patients' responses to bad diagnostic news are heavily dependent on the context of discourse in which physicians deliver it. Steele et al. (1985) find that patients' adherence is directly related to the form and specificity of physicians' questions. Moreover, Frankel and Beckman (1989a) observe that more than 90 percent of patients' formal complaints about their medical care focus on ways that health professionals communicate with them. Findings such as these indicate that the forms of talk that are employed between physicians and patients may well have practical consequences for patient care (cf. West and Frankel, in press).

In this paper, I am concerned with how physicians formulate their directives to patients and how patients respond to them. Following Goodwin (1980, 1988, in press), I view directive-response speech sequences as a means of establishing social order between parties to talk. Hence, my analysis focuses on the various social arrangements physicians propose through their directives and the responses these elicit from patients. My study of encounters between patients and family physicians suggests that women and men physicians use very different forms to issue their directives and that these forms yield different patient responses. In discussing my findings, I consider their relationship to the issue of patient adherence more generally and to the quality of patients' relations with women and men physicians.

**ON GIVING DIRECTIVES**

As Goodwin (1980: 157) notes, directives are 'speech acts that try to get another to do something'. As she also notes, alternative means of formulating directives—and responses to them—provide for a variety of social arrangements between parties to talk (Goodwin, in press: 74). For example, the use of aggravated forms, such as orders and demands, implies that a speaker can legitimately impose on another by stating their requirements baldly (Labov and Fanshel, 1977: 63, 84–5). By contrast, the use of mitigated forms, such as pleas and suggestions, allows a speaker to avoid offending another by putting forth their wishes in downgraded ways (Labov and Fanshel, 1977: 63, 84–5).

In her ground-breaking work on the subject, Ervin-Tripp (1976) found
that directive forms vary with the rank and familiarity of speakers and hearers. Her study of observed directives across a broad range of settings (including homes, hospitals, adult education classrooms, offices and a Marine Corps recruiting station) showed that their distribution followed a rough stratification system—according to the explicitness of the directive and 'the relative power of speaker and addressee in conventional usage' (Ervin-Tripp, 1976: 29):

*Need statements*, such as 'I need a match'.

*Imperatives*, such as 'Gimme a match' and elliptical forms like 'a match'.

*Imbedded Imperatives*, such as 'Could you gimme a match?' In these cases, agent, action, object and often beneficiary are as explicit as in direct imperatives, though they are embedded in a frame with other syntactic and semantic properties.

*Permission directives*, such as 'May I have a match?' Bringing about the condition stated requires an action by the hearer other than merely granting permission.

*Question directives*, like 'Gotta match?' which do not specify the desired act.

*Hints*, such as 'The matches are all gone'.

Her findings indicate that the use of alternative directive forms varies considerably across settings and situations and, hence, that variation is not merely a function of politeness. Perhaps more important, they demonstrate that the interpretation of a directive as a directive is dependent on its context: 'if the form is inappropriate to the context, it may not be heard as a directive at all' (Ervin-Tripp, 1976: 59).

To be sure, 'context' often serves as a proxy for a broad range of factors in the study of interaction, including the setting, the nature of the situation, the task at hand (if any) and the identities of the participants involved (Ervin-Tripp, 1976: 59; Goffman, 1964: 134; Goodwin, in press: 88; Hymes, 1964: 10). The distribution of different directive forms across diverse settings and situations raises important questions about how these factors are related to one another (Goodwin, in press: 87-8). It also raises questions about the turn-by-turn organization of conversation in which speech actions achieve a particular meaning or delineated range of meanings in a situated context (West and Zimmerman, 1982: 511). Goodwin's (1980, 1988, in press) research addresses these issues in fine detail by focusing on how alternative directive forms are fitted to the specific setting, situation and conversation in which they occur.

Her data consist of audiotapes and transcripts of conversations among Black working-class girls and boys (ages 9–14) at play in an urban neighborhood. She recorded these conversations over an eighteen-month period while observing the children’s organization of their play groups. Goodwin’s systematic analyses of these materials found that girls and boys used distinctive directive forms to coordinate their activities in dramatically different ways.

Among boys, tasks such as making slingshots were organized through the use of directives that emphasized differences between parties to talk:
Above, Michael issues his directives as explicit imperatives, his syntax stressing the distinction between himself (me) and his addressees (Poochie and Chopper).

Goodwin (in press) observes that the function of such directives is evident not only from their form but from their context in particular speech environments. For example, boys' imperatives often appeared in stretches of talk that focused on the degraded status of their addressees:

(Goodwin, in press: 99)
(39) Tony: Go downstairs. I don't care what you say you aren't—
you ain't no good so go downstairs.

(Goodwin, in press: 105)
(43) Douglas: Get outa here sucker.
(44) Chopper: You shut up you big lips.

They also appeared in utterances that used possessives (e.g. ‘mine’, ‘yours’) to formulate differential rights of ownership or access between participants:

(Goodwin, in press: 110)
(59) Tony: Get off my steps.

(Goodwin, in press: 120)
(68) Malcolm: Gimme your other hangers. I'm a bend them all.

Through these means, boys arranged their activities hierarchically, their aggravated forms establishing asymmetrical alignments between themselves and their addressees.

By contrast, girls used directives that minimized status differences between parties to talk:

(Goodwin, 1980: 165)
((Girls are looking for bottles))
(30) Sharon: Let's go around Subs and Suds.
Pam: Let's ask her 'Do you have any bottles.'
(31) Terry: Let's go. There may be some more on Sixty Ninth Street.
Sharon: Come on. Let's turn back y'all so we can safe keep em.
Come on. Let's go find some.

Here, for example, Sharon, Pam and Terry advance their plans (for making rings from bottle rims) as proposals, using 'Let's' to formulate their suggestions as invitations to collaboration. Goodwin (1980) observes that even these mitigated directives tended to be further modulated by the verb forms 'can' and 'could'.
(Goodwin, 1980: 166)

(Discussing how best to break bottle rims)

(41) Sharon: We could use a sewer.
(42) Pam: We could go around lookin for more bottles.
(43) Sharon: Uh we could um, (2.4) shellac em.

((Discussing keeping the activity of finding bottles secret from boys))

(44) Terry: We can limp back so nobody know where we gettin them from.

They also were further mitigated by terms such as ‘maybe’:

(45) Terry: Maybe we can slice them like that.

((Discussing obtaining bottles))

(46) Sharon: Hey maybe tomorrow we can come up here and see if they got some more.

These modulations further underscored the invitational flavor of girls’ directives, thereby proposing symmetrical relationships between speakers and their addressees.

Of course, the issuance of a directive (in whatever form) cannot establish a relationship between the speaker and addressee by itself, since responses constitute the second parts of the pair. But Goodwin (1980: 160) notes that ‘the format of the first pair part is characteristically implicative for the format of the second’. Thus, when compliance was not forthcoming, aggravated directives could receive aggravated responses:

(41) Huey: Gimme the things.
    Chopper: You sh:ut up you big lips.
(12) Juju: Terry go and get your pick.
    Terry: What pick, I’m not going in the house now.
(13) Michael: Get out of here Huey.
    Huey: I’m not gettin out of nowhere.

In these cases, non-compliant responses constitute both refusals of the directives and challenges to the speakers’ authority to issue them.

By contrast, non-compliant responses to mitigated directives took the form of counters to proposals:

(134) ((On reaching a city creek while turtle hunting))

(1) Bea: Y’all gonna walk in it?
(2) Ruby: Walk in it, You know where that water come from? The toilet.
(3) Bea: So, I’m a walk in it in my dirty feet.
(4) I’m a walk in it and I don’t care if it do come. =
(6) You could easy wash your feet.
(7) Ruby: ((to ethnographer)) Gonna walk us across?
(8) Yeah I’ll show y’all where you can come.

In these cases, rather than refusing directives, return actions offer arguments countering the appropriateness (lines 2–3) and consequences (line 4) of the action being proposed. Goodwin (in press: 147) observes that such
sequences do not establish hierarchical relations between parties to talk, since ‘counters to proposals are themselves counterable, and a proposal initiated by one party may be reinstated subsequently by another’. In sum, these findings show that both girls and boys employ directives to organize their task activities, but they do so very differently. Whereas boys use imperative forms to address subordinates (and requests, to those subordinate to them), girls use the same mitigated forms reciprocally with one another. Goodwin (in press: 147) concludes that ‘boys’ directives display distinctions between participants and stress individual rights [while] girls’ directives stress the connectedness of girls to each other and their caretaking concerns’. Through these means, boys and girls establish contrasting forms of social organization.

Goodwin’s work affords a systematic approach to the study of directives and responses—an approach grounded in the detailed empirical examination of tape-recorded conversations. Below, I employ this approach in my examination of encounters between physicians and patients; but first I describe my methods of data collection and analysis.

METHODS

Data for this analysis consist of 21 encounters between physicians and patients that were videotaped in a family practice clinic in the southern United States. The physicians in these encounters are residents in family medicine, a medical specialty that demands three years of additional training beyond medical school. Most are in their late twenties and early thirties. Seventeen of the encounters involve physicians who are white men and four involve white women.

Patients in these encounters range in age from 16 to 82 years. Their backgrounds are diverse, including those of unemployed carpenter, construction worker, domestic and professional. Of the 20 patients involved (one was seen by two different physicians in the course of his visit), five are white men; six, white women; five, Black women; and four, Black men.

The encounters themselves are actual patient visits to family physicians, so they are not standardized according to length, presenting complaint, or duration of relationship between physician and patient. The clinic at which they were recorded has used videotaping for over a decade as part of the ongoing training of residents. With their signed consent, patients are taped while visiting their physicians via ceiling microphones and unobtrusive cameras placed in the corners of examining rooms. In the analysis which follows, I employ pseudonyms to ensure the confidentiality of the physician–patient relationship.

To transcribe the tapes, I used a set of conventions developed by Gail Jefferson (see Appendix). The aim of these conventions is to capture as close to a verbatim version of interaction as is possible—to record what was said and how it was said in fine detail. In all, the 21 videotaped encounters yielded 532 pages of transcript.
Elsewhere (West, 1983, 1984a, 1984b, 1984c), I have used these data for other research purposes, such as the analysis of turn-taking, question-answer sequencing and repair between physicians and patients; and, in fact, the findings reported here did not emerge from any initial plan to study 'doctors' orders'. But in the course of a related research project, I observed such striking differences in the ways that men and women physicians formulated their directives to patients that it prompted a comprehensive examination of those directives in their own right.

I began my analysis by examining the transcripts to locate all instances of physicians' directives, that is 'speech acts that try to get another to do something'. I then examined the sequential contexts of these directives to further determine: (1) the speech environments in which they occurred, and (2) the responses—if any—they elicited from patients. Using this strategy, I encountered one problem that could not be resolved with the data at hand: it was virtually impossible to assess patients' responses to physicians' directives in the course of physical examinations. For example, when a physician told a patient to 'relax', 'loosen up' or 'tighten that muscle', I was often unable to determine what—if any—response this elicited, from examination of the videotape and transcript. And insofar as many of the directives issued during physical examinations had to do with patients' internal states, responses to them may not even have been detectable by the physicians involved. For this reason, I excluded directive-response sequences that occurred during physical examinations from the analysis which follows. With this exception, I inspected all the directive-response sequences that occurred in these data to assess how physicians formulated their directives and how patients responded to them. Because men and women physicians issued their directives in dramatically different ways, I present my findings separately for each.

DIRECTIVES OF MEN PHYSICIANS

Imperatives

Among the men physicians in these encounters, directives to patients typically took the form of imperatives. For example, 49 of the 156 directives they issued (or 31 percent) were formulated as explicit commands:

(1) (Dyad 01:749+)
Patient: So if I fe- fee:f this coming on, an' I'm sidding up in a plane, 'r I'm out somewhere in a car, .h 'n I c [an't lie dow-
Physician: LIE:: DOW:N!]

(2) (Dyad 02:114+)
Patient: I'm tryin' tuh (.2) sid o::n this tailbone duh try an' ged it bedder an' ev'ry chance I could [I try duh
Physician: (Oh:: don' even] try:::, if it hurts when yuh sid on it, stay off of it.

(3) (Dyad 05:258+)
Physician: Go ahead an' get this:,(,) ((hands patient the x-ray order)) an'
Above, for example, physicians employed imperatives to command patients with respect to future courses of action: 'LIE DOWN!' (if you feel this coming on), 'stay off of it' (if it hurts when you sit on it), and 'rub it all over yer face' (twice a day). But they also used imperatives to command patients regarding immediate courses of action:

(6) (Dyad 08:216)
Physician: TAKE OFF YER SHOES AN' SOCKS.
(7) (Dyad 17:387)
Physician: Take yer trousers o:ff.
(8) (Dyad 18:094+)
Physician: Pull off a shirt ((taps patient on the knee)) for me.
(9) (Dyad 10:252)
Physician: Sit for me right there:

In these cases, physicians' directives required return actions from patients then and there.

One command characteristic of all these commands is the authority they imply on the part of the speaker. As Goodwin (1980) observes, the formulation of a directive in imperative form makes implicit claims about the speaker's right to be issuing such a directive in the first place. In excerpts 1–5, physicians' formulations propose the legitimacy of their right to command patients with respect to their physical activities ('LIE DOWN!', 'stay off of it') and treatment ('get this' (X-ray)), 'Take one of each foah times a day'). And in excerpts 6–9, physicians' directives assert their authority to command patients to disrobe ('TAKE OFF YER SHOES AN' SOCKS', 'Pull off a shirt for me') and to move ('Sit for me right there'). What they thereby propose is an asymmetrical alignment between physician and patient, in which the patient 'has no choice but to do whatever told' (Shapiro, 1978: 170).

Need statements

Another way in which men physicians issued directives to patients was by stating those patients' requirements. For example, physicians frequently told patients what they 'needed to' or 'ought to' do:

(10) (Dyad 14:803+)
Physician: I think yuh need duh try: duh ged ou:t, even if yuh-..h y'know, sit an' watch o:ther people dance 'r whatever.
(11) (Dyad 18:208+)
Physician: It dozen hurt tuh keep movin' arou::n', but cha nee:d duh put

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the heat on it. (.6) An' (.2) yuh nee'd tuh get the as:pru:n into yuh tuh sorda make it to:ler'ble.

(12) (Dyad 18:261+)
Physician: We:ll, hh I'll write chew a thy::un ((meaning an excuse from work)) cuz I think you oughtta ...hh I think you oughtta knock tha::t o:ff fer awhy:ule-hhh. ((now writing))

Physicians also told patients what they 'had to' or 'had got to' do:

(13) (Dyad 02:393)
Physician: So yuh gotta be ril care:ful no:w (.8) you been (.8) .h BE:IN' CARE:FUL 'BOUT CUTTIN' YER TOE:NAILS?

(14) (Dyad 05:481)
Physician: YOU AN' [DOCKTUR] MOR:SE will hafta com:s [ult o:n ]hat:
Patient: [Ye:as. ] [°OKay]

(15) (Dyad 02:708)
Physician: An' you haf tuh sign the above: on thi:s
(16) (Dyad 07:682)

Ervin-Tripp (1976) describes 'need statements' as some of the most aggra-vated of directive forms, noting that they routinely occur between superiors and subordinates. However, in her data, such directives focused on the requirements of speakers themselves:

(17) (Dyad 13:016+)
Physician: As I sai::d, I don' think that- ((rifling through a drawer)) (.4) we should use: the: (1.4) that you: should use: (1.4) an Eye Yew Dee anymore. (3.6) Whi:ch- (.2) mea::ns:::s (.6) that whi haf tuh dihci:de on another method a birth control for yuh.

Above, for example, the physician first uses 'we' to refer to the-ones-who-should-be-using-an-intrauterine-device, but he quickly replaces this with 'you'. So, when he subsequently uses 'whih' to refer to the-ones-who-have-to-decide, the object of his decision-making belies the collaborative syntax he employs—here, 'we' have to decide for 'you' (not us). In this context, 'we' who-should-not-use-an-IUD-anymore is the patient, but 'we' who-need-to-decide-on-another-method-of-birth-control is the physician himself. The next excerpt shows a similar statement of pseudo-mutual requirements:

(18) (Dyad 20:234+)
Physician: So yuh might wanna take some li:ddle no:tes. h Yer gunna ha:f
tuh .hh yer gunna take some rihsponsuhbli:idy fer this ((taps
foot)) cuz we're gonna 'aftuh ((points his right index finger at
her)) figger ou:t whether .hh we need duh do some tes:ts er
no:t.

Here, again, the physician invokes the prospect of joint decision-making by
his use of 'we' with reference to the-ones-who-are-going-to-have-to-figure-
out-whether-to-do-some-tests. However, this pseudo-mutual statement
appears in the same stretch of talk in which the physician tells the patient
that she's going to take some responsibility for this, and as he formulates
what 'we're' going to have to do, he points his finger directly at the patient.
Hence, like other statements of patients' requirements (e.g. excerpts 10–
17), these directives propose the physicians' authority to assess patients'
needs and determine what is best for them. What they propose simulta-
neously is a hierarchical relationship between physician and patient.

Want statements

Still another means of issuing directives to patients was the physician’s
statement of his own preferences for patient action. Typically, such state-
ments were formatted with reference to what the physician 'wanted' or
'didn't want' the patient to do:

(19) (Dyad 05:323+)
Physician: Uh:m, if you:: in th' MEAN::time start havin' FE::Ver er
shakin'= CHI::lls (.).h any problems like that,.h then ah
wan' uh- then I wa:n' cha duh git back with who'sever on ca::ll
(20) (Dyad 09:109)
Physician: I do: wan' cha tuh go ahead an' get that Li:ght Salt.
(21) (Dyad 20:220+)
Physician: Whud I: wan' cha duh do: fer me: is I wan' cha duh keep a
goo: d record of whe:n yuh have that pai:n. How o::ffuri yuh
have it? (1.2) Whe:n it oc cu::s? (.2) .h an' whu::t cher do::ng
whe:n yuh ha:ve it.

But sometimes physicians' statements of preference were modulated by
what they 'would like' patients to do:

(22) (Dyad 08:183+)
Physician: AH'D AL:SO LIKE FER YUH TUH TAKE OFF YER
SHOES AN SOCKS UN- AH: ((drawing curtain to 'create' an
examining/dressing room)) TROU:SERS
(23) (Dyad 09:684+)
Physician: Lemme tell yuh whud I- .h lemme tell yuh whud ah'd like yuh
duh do: now, ah'd like yuh to::: (. ) see whut arrangemun's yuh
wanna make.

And, occasionally, they were further downgraded by their formulation as
physicians' own desires:

(24) (Dyad 05:296+)
Physician: So:::. (4) tch whud ah'd li:ke tuh do: (.) is
Above, for example, the physician involved in both excerpts states what he would like to do (i.e., put the patient on some aspirin and see her back on Thursday). However, fulfillment of his wishes will in both cases require specific actions on the part of the patient: namely, that she take the aspirin and that she return to be seen on the appointed day. Thus, his statements function like other statements of physician preference (excerpts 19–23): that is, as directives for patient action.

As others have observed, statements that refer to the speakers’ wishes are among the most aggravated of directive forms (Goodwin, 1980: 160), proposing that speakers’ preferences imply an obligation on the part of their addressees (Ervin-Tripp, 1976: 29).

Quasi-question directives

Closely related to statements of preferences and needs were physicians’ directives that employed ‘Why don’t you . . .’ to preface stipulations for patient action:

(26) (Dyad 09:266+)
Physician: Why don’ yuh ((patient rises)) take (.h in that case, bo:th yer shirt a::n’ yer undershirt off.

(27) (Dyad 16:365+)
Physician: Why don’ chew cor.me ((.2 in: (.2 ) I guess that ah’m gonna hafta make that in two: weeks

(28) (Dyad 17:378+)
Physician: Ok.a:y, wall, why don’cha jump up on the table. ((doctor leans forward to push himself out of the chair. As he does so, patient does too.)) (.6) An’ ah’ll take a look ad it.

As Ervin-Tripp (1976:29) notes, the objects of such directives are put forth as baldly as in imperatives (e.g. ‘take both yer shirt an’ yer undershirt off’, ‘come in in two weeks’, and ‘jump up on the table’). And despite their interrogative forms, these directives are rarely advanced with the rising intonation that characterizes questions. Indeed, physicians formulated them in ways that demanded actions—rather than answers—in return. Thus, these directives also implied an asymmetrical alignment between parties to talk, highlighting the distinction between speakers and their addressees.

Permission provisions

Yet another form of aggravated directive I observed in these data was the giving of permission for a particular course of patient action. In this case, physicians’ syntax proposed a strong contrast between themselves and the patients they addressed:
(29) (Dyad 02:249+)
Physician: I think that's-that's alright from time-duh-time... I would ex::peck that-prob:ably::: within: the next wee:k or so, hh you won' need it anymore.

(30) (Dyad 09:126)
Physician: [Ah'm not s] a:ying yuh never cun [ha::ve] these th [j:ings, it's just] as a ru::le, that shouldn' b [e a daily .hh]

(31) (Dyad 13:116+)
Physician: Yih cun start on the three-month supply:, an' yih cun re:fill that three times, over the course of a ye:ar.

(32) (Dyad 17:725+)
Physician: (I'm) jus' gonna ((pulls the curtain open)) get 'ts all- open for yuh- jus' hold o:n fer a sekkin'=.h you cun put cher trou:zers o::n. (.4) In the meantime.

Above, for example, 'you can' and 'that's alright' specify what the patient is permitted to do, while 'I think' and 'I'm not sayin' ' specify the physician's authority to be granting permission. Among these physicians, the identity of the authority giving permission ('I', the physician) was often omitted (as in the cases of excerpts 35 and 36), thus granting authority by fiat.

Of course, Ervin-Tripp (1976) also discusses 'permission directives', noting that they tend to occur between parties who differ in rank. But there (1976: 37–8), she is dealing with directives that request permission from addressees (e.g. 'Can I have my records back?', 'May I have the salt?'); here, I am dealing with directives that grant it. In this sense, the forms of directives we identify are mirror images of one another: both propose a hierarchical relationship between speakers and their addressees, but 'permission directives' imply the speakers' subordination ('Can I have X?') while 'permission provisions' assert their superiority ('You can have X').

Directive by example

Another distinctive way that men physicians 'tried to get patients to do things' was by stating what they themselves would do:

(33) (Dyad 05:519+)
Physician: [Ah] would do that. [Ah'd drink] plen'y a flu:ids, =ah'd take that as:prun ruhlig:ously (.).h an' if yuh need duh stay ho:me=stay home.

(34) (Dyad 10:862+)
Physician: An' ah'd take one: a tho:se four times a da:y, an' if ne:cessary,.h yuh cun take two: at bedti:me. (.2) .h An': (. ) what ah: would do: is tuh stay::y on that fer about-.h ten da:ys 'r two wee:ks?

(35) (Dyad 18:275+)
Physician: Wu:ll, if tuhda::y's Mo::nday, hh (1.2) ah'd prob'ly lay off till about Thurs::day.

In these cases, the status of physicians' directives as directives is hardly unclear. Like Ervin-Tripp's (1976: 29) need and want statements, these assertions specify what the patient is to do as explicitly as any imperative
('drink plen'y a fluids', 'take that asprun ruhligously', 'stay on that fer about ten days 'r two weeks', and 'lay off ((of work)) till Thursday'). But here, the form of the directive ('I would do X') implies that the patient should engage in a particular course of action simply because the physician would do so. Ironically, then, this 'indirect' directive is perhaps the most aggravated of them all: not only does it exaggerate the distinction between speaker and addressee, but its form proposes that the speaker's inclinations should serve as a model for others' behaviors.

**Imbedded imperatives**

To this point, I have focused on the most aggravated forms of directives because these constituted the vast majority (81 percent) of the directives men physicians used. However, there were occasions on which they employed less aggravated directives, such as imbedded imperatives:

(36) (Dyad 02:695)

Physician: Could ju give that tuh th' bizness office on yer way out?

(37) (Dyad 09:103+)

Physician: We:ll the most I cun ask yuh duh do

tuh cut down:

Patient: [Cut down, uh-huh]

(38) (Dyad 20:143)

Physician: Can you: put cher fing:er on the place where yuh uj:ly have the pa:in?

Above, the imbedding of 'can' and 'could' into otherwise explicit commands ('give that to the business office', 'cut down', and 'put cher finger on the place') downgrade the imperatives to requests—rather than demands—for patient action. The use of 'ask' in excerpt 37 and questioning intonation in excerpts 36 and 38 further modulate these directives as requests.

But as others have pointed out, such directives still explicate the agent and object of action (Ervin-Tripp, 1976: 33), and they still emphasize the distinction between the speaker who poses the request and the addressee who is asked to fulfill it (Goodwin, 1980: 160). Thus, they too propose an asymmetrical relationship between parties to talk.

**False collaboratives**

A final form of directive I identified in the talk of men physicians was the 'false collaborative'—a directive that is formatted as a proposal for joint action, yet actually proposes action to be undertaken by a single individual. For example, on first inspection, the excerpts just below would appear to present suggestions for collaborative activity between speakers and their addressees:

(39) (Dyad 10:708+)

Physician: Oka:y ((doctor walks around to the rear of the patient)) Let's

slip this back off, an' get chur blouse back o:n ((doctor carefully unties the patient's gown; he removes one sleeve from her arm, and then removes the other))
Here, physicians employ the 'Let's do X' format that Goodwin (1980, in press) identifies as a means of proposing joint plans of action between speakers and hearers. But in these excerpts, actions specified by the directives are not ones that both parties can or do engage in: in excerpt 39, it is the physician who removes the patient's gown; and in excerpt 40, it is the patient who must return in two weeks. In these contexts, 'let's' implies a form of pseudo-participation in joint action (Ervin-Tripp, 1976: 48), one that parodies, rather than enacts, a true proposal. Simultaneously, it exaggerates status differences between physician and patient by highlighting (almost satirically) the distinction between them.

In short, men physicians employed directives that functioned as comparisons, emphasizing the distinctions between their patients and themselves (Goodwin, in press: 74). Through imperatives, imbedded imperatives and statements of their needs and wants, they made implicit claims regarding their authority to impose their demands on patients and patients' obligations to fulfill them. Moreover, physicians' 'permission provisions' and 'directives by example' afforded a stark contrast between those who have rights to issue 'doctors' orders' and those with obligations to follow them. Even physicians' use of less aggravated forms—imbedded imperatives and false collaboratives—stressed the difference between the speakers who posed the directives and the addressees who were expected to comply with them. Through these means, men physicians proposed an asymmetrical relationship between their patients and themselves—one that stressed patients' obligations in contrast to physicians' rights.

DIRECTIVES OF WOMEN PHYSICIANS

By contrast with men, women physicians issued their directives in decidedly mitigated forms. Through such means, they minimized distinctions between themselves and their patients and proposed symmetrical physician–patient relationships.

Proposals for joint action

For example, women physicians often formulated their directives as proposals for joint action. One way of advancing these proposals was the 'Let's do X' format Goodwin (1980, in press) describes:

(40) (Dyad 12:309+)
Physician: 'Bout uh: let's have yuh come back in about- hh two: weeks.

(41) (Dyad 04:370)
Physician: .h Let's talk about cher pressure fer a minnit 'r two. .h-.h-.h-ch-hhhhew! 'Okay. ((sounding congested))

(42) (Dyad 11:569+)
Physician: OKa:y! Wull let's make that our pla:n,
Physician: So::: Let's stay on- uh::: what we're doin' right no:w. Okay?

Physician: .h Let's get a fasting sugar nex' time too: (.2) OKa:y?

Above, physicians use 'Let's' to include themselves and their patients as partners in the actions they propose: talking (about the patient's blood pressure), making a plan for future treatment, staying on their present plan, and getting a 'fasting sugar' on the occasion of the patient's next visit. Unlike the false collaboratives discussed earlier, these directives formulate activities that both parties will play a part in, be it having a conversation or planning a course of treatment. Even getting a 'fasting sugar' will in this case require the coordination of two people: the patient, who must refrain from eating prior to taking this blood test, and the physician, who must schedule the test and interpret its results.3

Another way of proposing joint actions was formulating them as characterizations of what 'we' can or could do:

Physician: OKay, so: whadda yuh thi:nk,= maybe wih'd jus' take the top of yer- yer dress o:ff?

Here, for example, 'we cun' and 'wih'd jus' emphasize the tentative character of what physicians and patients might undertake.

Women physicians also employed 'we' in formulations of what they and their patients 'ought to' or 'had to' do:

Physician: Maybe whut we ought a do: is- is stay with (.2) . h the do:se of di(avecmez) yer o:n.

Physician: We both hafta take rihspon [sabil] ity, [right?]

Albeit 'ought to' and 'have to' are commonly used in aggravated directives, here, their coupling with 'we' includes both the physician and the patient in the actions they propose (staying with the present dose and taking responsibility). Thus, such formulations do not construct demands, as they might if only the addressees were subjects of actions they specified (Goodwin, 1980: 167). Rather, they build proposals for joint action between speakers and addressees. Through such formulations, women physicians made implicit claims to symmetrical relationships with their patients—ones in which they 'both had to take responsibility'.
Singular suggestions

Of course, all 'doctors' orders' cannot involve physicians as co-partners in the actions they propose. Some tasks, such as those that will be required after leaving the physician's office, can only be performed by patients. In the case of such tasks, women physicians used 'you' to formulate their directives to patients but they typically imbedded these in 'can' and 'could' modal verbs:

(49) (Dyad 04:226+)
Physician: One thing yuh could d [\ldots] \ldots h= is tuh eat, say, the meat first'. Yuh know, but if yuh have a salad tuh eat, t' save that till after yuh eat the meat. (\ldots) Cuz the salad's supposed tuh be cold... hh Somethin' like that (\ldots) 'OKay?

(50) (Dyad 04:243+)
Physician: An' then maybe yuh can stay away from the desserts an' stay away from the... h food in between meals. All the snacking, 'that kinda thing.

(51) (Dyad 19:342+)
Physician: Well, you could try: taking... h two: ev'ry four hou::rs if yuh needed to:... you could take that many an' see: an' that's... h it's a very strong medicine fer arthri [\ldots]

Like the imbedded imperatives discussed earlier, these directives identify actions to be performed in explicit terms (i.e. 'eat the meat first', 'stay away from the desserts', and 'take that many an' see'). But here, imbedded imperatives are downgraded to the status of mere suggestions through the inversion of subjects and verbs: not 'could you eat the meat first' but 'you could ... eat the meat first'; not 'can you stay away from the desserts' but 'you can stay away from the desserts'; and not 'could you take that many' but 'you could take that many'. The resulting directives advance proposals—rather than requests—for action, thereby de-emphasizing distinctions between speakers and addressees.

To be sure, the directives issued in excerpts 49–51 were further mitigated by the local contexts in which they occurred. Eating the meat first is put forth as just 'one thing' among many the patient in excerpt 49 could do; staying away from desserts is an action the patient in excerpt 50 'maybe' can take; and taking two every four hours is something the patient in excerpt 51 'can try ... an' see'. Such modulations were typical of women physicians, who rarely issued their directives baldly. For example, they often used 'maybe' to underscore the suggestive nature of their directives:

(52) (Dyad 11:619+)
Physician: It's good duh look,=an' look between yer toes,=make sure they're clean an' dry,: maybe yuh wanna put pow:der on um... Depen'ing on how swe-het-ty yer feet get! (\ldots) But y'know, check um! Maybe: y'know, maybe: (\ldots) if yer not: feelun' (\ldots) the:n yuh might see: somp'um thet cha don' fee:l.

(53) (Dyad 04:292+)
Physician: Maybe yuh ne- yuh need tuh dis-ci:pul yerself a liddle bit? ...h If yuh come ho:me from work? h sometimes I fi ne thet when I ride my bi:ke home thet that's a good way of unwi:n [\ldots]
Here, 'maybe' downgrades statements of patients' wants ('yuh wanna put powder on um') and needs ('yuh need tuh disciplun yerself') to the status of propositions, thereby mitigating their impact. In the process, the physicians imply a non-hierarchical alignment with their patients—one in which patients' wants and needs are perhaps hypothesized, but left to be determined by patients themselves.

Permission directives

On occasion, women physicians even sought patients' permission to be directed through the formats they employed. As Ervin-Tripp (1976: 37–8) observes, permission directives require some action by addressees beyond the granting of permission:

(54) (Dyad 11:716+)
Physician: Could I: u:m (. ) um: (.6) Rather then having yuh wait today, since I know: yer takin' off work, an' I need duh see another patient, h (.8) Could I have yer phone number? an' give yuh a [call then] When I get that [report] from him?

(55) (Dyad 03:270+)
Physician: Okay, lemme jus' say one thing: at this point, an' that is (.6) h no't be discouraged by what happened.

In excerpt 54, the physician asks the patient for her telephone number, in addition to her consent to being called later on. In excerpt 55, the physician asks the patient to listen to her forthcoming suggestion by formulating her request ('Lemme jus' say one thing') as a 'preliminary' to the action being proposed (Schegloff, 1980). In these cases, physicians avoided comparisons between their patients' status and their own by highlighting patients' prerogatives to counter the proposals they advanced.

Inverse imperatives

As I have already noted, women physicians in these encounters made little use of aggravated directive forms. Those they did use were often noteworthy not only for their rarity but for the contexts in which they appeared:

(56) (Dyad 04:061+)
Physician: Yih wan' me tuh-tuh give yih some guide:lines here? (1.0) Tell me what chuh ate: tuesday. Umm: y?

(57) (Dyad 19:033+)
Physician: Cuz if you: duhhide you want it off, you let me know. (. ) Okay?

(58) (Dyad 19:522+)
Physician: O:Kay, hh So: (looking at the patient) priddy much right no:w, h you tell me if I go: this, you got duh- (.2) duh pro-. h you need duh get yer me: dicine filled?... An' yih feel like yer pressure's okay, you are:n't having headache:s, or prob: lms see:ing.
Above, physicians formatted their directives as explicit commands, but they did so in contexts that implied patients should direct them: 'Yih wan' me to give you some guidelines here?', 'If you duhcide you want it off', and 'You tell me if I've got this'. Insofar as physicians thereby implied that patients were the ultimate authorities regarding the actions they specified, they affirmed their obligations to respect patients' rights to make the final decisions in such matters.

In sum, women physicians employed directives that minimized status differences between their patients and themselves and provided for more symmetrical arrangements of their relationships (cf. Goodwin, in press: 74-5). Through proposals for joint action, they made implicit claims regarding the collaborative character of the activities they suggested and patients' status as co-partners in decisions to implement these. Their directives regarding patients' individual actions were modulated by 'can', 'could', and 'maybe', stressing patients' prerogatives in planning such actions. Even their aggravated directives emphasized patients' authority to direct them, affirming their responsibilities to patients. Thus, women physicians proposed a more egalitarian relationship between their patients and themselves—one that emphasized physicians' obligations as well as patients' rights.

RESPONSES TO DIRECTIVES

As noted earlier, the data at hand consist of actual patient visits, so they are not standardized by duration, presenting complaint or length of relationship between physician and patient. Some physicians and patients had sustained a three-year relationship at the time they were recorded, whereas others were meeting for the first time. Some visits were routine follow-up checks on chronic conditions; others entailed discoveries of new complaints. And although all visits were scheduled for at least 30-minute time slots, some took considerably longer than 30 minutes; others took less. For these reasons, the tasks involved in particular visits varied widely and it is difficult to classify responses to directives via a standardized coding scheme.

Moreover, as Goodwin's work (1980, 1988, in press) demonstrates, directive-response speech sequences form adjacency pairs (Schegloff, 1972; Schegloff and Sacks, 1974), whose meaning is established through the turn-by-turn organization of talk in situated contexts. Some directives formulate future courses of action; others specify actions to be taken then and there. Some directives require verbal responses from addressees; others require no other response than performance of the action they propose. Hence, the intelligibility of responses to directives as responses to directives cannot be determined apart from the contexts in which they occur.

Below, I provide a detailed examination of two directive-response sequences in which it is possible to compare responses to aggravated and mitigated directive forms. Following this comparison, I present overall rates of compliance with alternative directive forms among patients in this collection.
Aggravated vs. mitigated directives

A common site for directives in these data was where physicians needed to get patients to disrobe in preparation for physical examinations. In the excerpts just below, two physicians attempt to achieve this end with patients they are meeting for the first time. Excerpt 59 involves a man physician and a man patient; excerpt 60 involves a woman physician and woman patient.

(59) (Dyad 17:385)
Physician: You can drop yer trousers, fact, why don' cha jus' take 'um off.
(.6)
Patient: ((leans forward on the examining table, looking at the physician))
Physician: Take yer trousers off.
(.6)
Patient: Eh:::----hh
(1.0)
Physician: Oh:, o:;kay, yuh wan' the cam'ra? ((physician reaches over and draws the curtain around the table so that the patient is hidden from the camera))
(.8)
Patient: °Uh::: ch::::::-- "eh-huhh! (.4) Ah don' wanna drop my trousers, at's alright-heh!
(.2)
Physician: You don' want to:=
Patient: =No:::
(60) (Dyad 19:682+)
Physician: Okay, so: whadda yuh thi:nk, =maybe wih'd jus' take the to:p of yer- yer dress o:ff?
[Would that be ok::y] with [you::?
Physician: [Uh, o::;kay, ye ]'s.
[O ] kay!

In excerpt 59, the physician issues two aggravated directives in quick succession: first, a permission provision ("You can drop yer trousers") and then, an imbedded imperative ("why don' cha jus' take 'um off"). Following a brief pause (.6), during which the patient does not undertake the action he specifies, the physician reissues his directive as an explicit command ("Take yer trousers off").

As in the case of other adjacency pairs (e.g. questions and answers or summonses and replies), directives and responses form a conditionally relevant two-part sequence (Schegloff, 1972; Schegloff and Sacks, 1974). In other words, given the occurrence of a directive, or 'first pair part', a response, or 'second pair part' is expected. And, given the occurrence of the first pair part, the absence of a second pair part is accountable—that is, it provides a warrant for repeating the first pair part or for some inference regarding the absence of the second (Schegloff, 1972: 77). In the case of excerpt 59, the patient's lack of response to the physician's initial directives provides grounds for his repetition (and, apparently, his starker formula-
tion) of the directive in his next turn. It also provides the warrant—following the patient’s further lack of response—for the physician’s inference regarding the patient’s reluctance to comply.

Finally, the patient issues a negative response to the physician’s directive in aggravated form (he doesn’t want to). And when the physician repeats the patient’s response, thereby offering him the chance to repair it (cf. Schegloff et al., 1977), the patient instead states his refusal baldly (‘no’).

By contrast, the physician in excerpt 60 puts forth her directive as a proposal for joint action (‘maybe wih’d jus’ take the top of yer dress off?’). Before she can fully follow this up with a request for the patient’s permission (‘Would that be okay with you?’), the patient has already issued an affirmative response (‘Okay’). Moreover, the patient provides further affirmative replies (‘fahne’, ‘good’, ‘yes’) as the physician’s request unfolds.

The difference I want to focus on in these very rich excerpts is between the two approaches to formulating directives. In excerpt 59, the physician’s aggravated forms imply that the patient has no choice but to comply with his demands; in excerpt 60, the physician’s mitigated form implies that the patient can counter her proposal, should she choose to do so. In each excerpt, the physician’s directive form is implicative for the formulation of the patient’s response: an aggravated reply in excerpt 59, and a mitigated one, in 60. And in excerpt 59, the aggravated reply is a negative response; in 60, the mitigated reply is an affirmative one.

Of course, neither response constitutes execution of the action specified by the physician’s directives—namely, to disrobe. However, in the case of excerpt 60, what follows is compliance with the directive:

(60 cont’d) (Dyad 19:693+)

Patient: It uh:n ((beginning to pull the hem of her dress up)) (2.0) It ‘on’ zi:p y’know, .h I gaw’ no zippuh (‘thad it can come off) ‘eh-hunh!
(1.0)
((physician walks toward the patient, who is standing by her chair with her dress halfway up))

Physician: ((leaning sideways to see the patient’s back)) Yih godda zipper there yih wan’ me duh help with?
(.4)

Patient: Ain’ got no sor:ta zip- ((as physician reaches over to help)) tuh come dow::n?

Physician: Oh:::, the zipper’s sew [n u:::p! Oh::!: You go:dit taken
Patient: [Yay:::us! engh-eheng-eheng-hengh]
Physician: caue off! [huh: heh-heh!]
Patient: [Yeah-heh-heh] heh!=
Physician: = ’heh 5Ah:kay! ((turning to walk back toward the examining table as the patient proceeds to undress))

But in the case of excerpt 59, what follow are further negotiations regarding the patient’s refusal to comply. For example:

(59 cont’d) (Dyad 17:406+)

Physician: This kine a personal to: yuh?
Patient: Ye::ah! (.4) Um-hmm.

Physician: Anything yuh'd like tuh as:k me about? 'r (uh::)=

Patient: =°No:::; (. ) engh-hh!

Physician: Cuz I ain' gonna .h y'know, I: ain' gonna mess arou::rť y'know. I [jes' wanna take a loo:k

Patient: °Oh:::::. (.6) No:, (ah'd love tuh have yuh check 'em,),

Physician: cher kne::s

Patient: °Oh::::; (.6) No:, (ah'd love tuh have yuh check 'em,) buh=not=right=there, that's why I don' like tuh go duh the
dock:tuh that much. (.4) Cuz uh::::; (1.2) Nu:hh:::hh (1.2) I let
yih check any o:thuh things, but not down he::ah. Drop my
pa: :ns l=no:::::siree::: !

Finally, following this series of unsuccessful attempts, the physician switches
to a mitigated approach:

Physician: Would juh like- (.2) .h it's- see:, it's RI::LLY HAR::D, ay:e-

Patient: °Ye:ah, wull m ' ay: be, buh uhi

Physician: [CUZ I: JUS' ] don't thi:nk I could

Patient: °Okay.

And here, the patient finally issues an affirmative response: initially quali-

Physician: h Cun yuh try: 'n do tha:t?

Patient: Yeah, I: 'll try a do: it.

And additionally, the physician switches to an aggressed directive:

(59 cont'd.) (Dyad 17:440+)

Physician: I:'ll tell yuh wha:t. Ah:'ll close a drapes hh (1.0) ((walking over to the curtain pull)) Here (.6) ((sound of curtains being
closed fully around the examining table)) hh 'N I wan' chow:

(1.0) ((more curtain noises)) tuh drop yer trouses: .h jus' lay:

In effect, his reversion reasserts his authority to command the patient in the

The point of this detailed comparison has been to show that patients' responses to 'doctors' orders' are highly sensitive to the ways in which those
orders are advanced. From this vantage point, an affirmative response is not merely the product of one individual (i.e. the patient), but the outcome of highly intricate negotiations between speakers and their addressees (cf. Frankel and Beckman, 1989b).

Patients' compliance with physicians' directives

With the data at hand, it is impossible to determine long-term patient adherence to medical advice. Videotapes and transcripts of patient visits simply do not permit access to what happens after physicians and patients part company. So, while physicians issue many instructions for future action, these data permit me to assess patients' responses to those instructions only then and there.

However, as in the case of the excerpts just presented, there is much to be learned from the detailed examination of physicians' formulations of their directives—and patients' responses to those directives—in the situated contexts in which they occur. For example, I can identify cases of compliance with physicians' directives where patients undertake actions specified by those directives in adjacent turns:

(61) (Dyad 15:542+)
Physician: °Ah wancha duh gi:t back u:p heah foah me pleez. hhh
Patient: ((walks over to and sits down on the examining table))

I can also identify cases in which patients' responses to physicians' directives assert their willingness to comply in the future, either by explicit statements:

(62) (Dyad 18:336+)
Physician: Now, don' jus' la::n without that hea::t on it, cuz 'at rilly- hh (.6) Ah cain' tell yuh how it duz:: it, but (.1) it wi::ll (1.2) you'll gedda fee:lin: bedder quicker. h
(1.2)
Patient: Ah: won't. hh

Or, by affirmation:

(63) (Dyad 11:642+)
Physician: Those 'r some a the things thu: that (.4) ma::y be a problum layder o::n, but right now: (.2) I don' see thu: they are:::. (1.2) But. °Let me know: if any of 'um are::. an' we'll work tuhge:ther on thum.=
Patient: =°Alright.

By contrast, I can identify non-compliance with physicians' directives where patients refuse or fail to undertake actions that are specified in next turns (as in excerpt 59, presented earlier). I can also identify cases of non-compliance where patients' responses display their lack of agreement with physicians' directives:

(64) (Dyad 09:631+)
Physician: Why don' yuh do thi::s, why don' yuh call them, an:d u:h. (.) See what they sa:y. An' after thu: t, you call
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back here, an'- an' talk duh Norma, an' leddum know what they sai:d, an' then ah'll get back to yuh:. (.4) .h An' we cun arrange whudever's necessary for: yu [h:;], so:

Patient: [Wull]=I=wan] na check on it muh:ney-wise firs'.

(65) (Dyad 14:803+)

Physician: I think yuh need duh try: duh ged ou:t, even if yuh- .h y'know, sit an' watch o:ther people dance 'r whatever (.4)

Patient: ('M: that's-) Wull, that's- that's the trouble with not bein' able duh drive, y'know? yer dihpe.vzdun' on othuh people.

In excerpts 64 and 65, for example, neither patient explicitly refuses to comply with their physician's directive. But insofar as physicians' directives constitute their assessments of what patients should do, and insofar as agreement with assessments is strongly preferred in next turns at talk (Pomerantz, 1984), these patients' lack of agreement with physicians' directives ('Wull, I wanna check on it muhney-wise firs'; and 'Wull, that's the trouble with not bein' able duh drive') can be seen as something other than willingness to comply with 'doctors' orders'.

Finally, I can also identify non-compliance with physicians' directives where patients fail to respond to those directives:

(66) (Dyad 13:116+)

Physician: Yuh cun start on the three month supply:, an' yih cun re:fill that three ti:mes, over the course of a ye:ar. (13.8)

(patient is silent as the physician makes notes in her medical record)

Physician: If yih should have any problum with (. ) pai:n an' swelling in yer lay:gs 'r any difficuldy brea:thing, (.8) .h yuh let me know right away. Okay? (26.4)

(patient is still silent as the physician continues to write)

Above, the patient issues neither verbal nor nonverbal responses to the directives her physician has issued. Given that the occurrence of a directive warrants the occurrence of a response (Schegloff, 1972; Schegloff and Sacks, 1974), the absence of a response can be seen as an 'official' absence, and hence as non-compliance with the directive.

Among patients in this collection, rates of compliance varied with the forms of physicians' directives. For example, men physicians' imperatives (e.g. 'LIE DOWN!') elicited compliant responses in 47 percent of the total (49) cases in which they were used—in short, less than half the time. Their statements of preference (e.g. 'Ah don' wan' cha duh (take both') were more successful, yielding compliance in 59 percent of the total (22) cases. However, their statements of patients' needs ('What cha need tuh do is . . .'), permission provisions ('you can refill these three times') and directives by example ('Ah'd take two ev'ry four hours') fared much worse, eliciting compliance in only 38 percent of the (16) need statements; 36 percent of the
permission provisions; and 29 percent of the directives by example. The directives of men physicians that were most successful in eliciting compliant responses were those that took less aggravated forms. False collaboratives ('Let's slip this back off') yielded compliance in 65 percent of the total (23) cases, and physician requests ('Can you put chee finger on the place?') achieved their objectives in 4 out of 5 (or 80 percent) of the cases in which they were used. As a rule, the more aggravated the directive, the less likely it was to elicit a compliant response.

Among women physicians, this rule also held, albeit since the vast majority of their directives took a mitigated form, there was less variation among the responses they received. For example, proposals for joint action (e.g. 'Let's make that our plan') elicited compliant responses in 67 percent of the (9) cases in which they were used. Singular suggestions for patient action ('you could try taking two ev'ry four hours') fared even better, yielding compliance in 75 percent of the total (8) cases. Perhaps most remarkable were their inverse imperatives ('You tell me if I got this'): these produced compliant responses in 8 out of 9—or 88 percent—of the cases in which they appeared. By contrast, of the 4 cases in which women employed quasi-question directives ('Why don' chew put these away'), only one was successful in achieving its specified aim.5

Thus, for women physicians too, the more aggravated the directive, the less likely it was to elicit a compliant response. The difference is that women physicians used aggravated imperatives less often than men did. And, their overall rate of compliant responses was 67 percent—in comparison to 50 percent for men.6

CONCLUSIONS

'Doctors' orders' are often satirized in the admonition 'Take two aspirin and call me in the morning'. Quite apart from the banality of this directive (employed under a seemingly infinite set of circumstances), we can note that it takes the form of an imperative—an explicit command from the physician to the patient. As I have already pointed out, the formulation of a directive in this aggravated form emphasizes the distinction between the speaker and the addressee and asserts the speaker's authority to be issuing commands in the first place (Goodwin, 1980).

Among physicians in this collection, men used aggravated forms that emphasized differences between their patients and themselves, and proposed hierarchical physician-patient relationships. Women physicians employed mitigated directives, which minimized status differences between physician and patient and stressed their connectedness to one another (cf. Goodwin, in press: 147). These alternative formulations were consequential for patients' responses: not only were aggravated forms less likely to elicit compliant responses, but women physicians elicited such responses more often than men did.

Since my data were not generated by random sampling techniques, and
since there were only four women physicians in this collection, it would be inappropriate to generalize from my results to women and men physicians at large. But should these findings hold in larger systematic samples of physicians, they might prove useful in explaining why patients are more satisfied with women physicians (Linn et al., 1984) and less likely to sue them for malpractice (Holder, 1979).

To be sure, compliance with physicians' directives is not the same thing as long-term adherence to medical advice. Further research is needed to determine precisely how patients' responses to physicians' directives relate to their adherence to medical advice over time. However, in light of Carter and his colleagues' finding that patients' indicated willingness to follow medical advice is the best predictor of their actual adherence (Carter et al., 1986), my results offer a promising new direction for future work on this problem.

Finally, it would be difficult to close this paper without commenting on the significance of my findings for our understanding of the relationship between language and gender. For example, what should we make of the fact that the distribution of aggravated and mitigated directives among these white middle-class physicians is so similar to their distribution among Black working-class boys and girls (Goodwin, 1980, 1988, in press)? The lesson to be learned here is not that the 'essential natures' of women and men determine their interactional styles—including their tendencies toward politeness (Brown, 1976); 'indirect' language (Lakoff, 1975); and 'conversational insecurity' (Fishman, 1980). After all, women physicians can use aggravated directives on occasions of conflict with patients (see notes 5 and 6), and girl children do use aggravated forms to order their younger siblings around (Goodwin, 1980, in press). The lesson, I think, is that the mundane activities of social life—be they making slingshots or getting patients to disrobe—provide the interactional resources for 'doing gender' (West and Zimmerman, 1987), that is, exhibiting, dramatizing or celebrating our 'essential natures' as women or men in accountable ways.

Acknowledgment. For their helpful comments on an earlier draft, I thank Richard Frankel, Marjorie Goodwin, Barbara Sharf, Gilly West and James West.

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APPENDIX

The transcript techniques and symbols are based on those devised by Gail Jefferson in the course of research undertaken with Harvey Sacks.

A: I had them
B: [Did] you

Brackets around portions of utterances indicate that the portions bracketed overlap one another. Segments to the left and right of these denote talk in the clear.

B: 'Swhat I said=
A: =But you didn't

An equal sign is used to indicate that no time elapsed between the objects 'latched' by the marks.

?!

Punctuation marks denote intonation, not grammar.

LOUDLY

Capital letters are used to mark speech that is much louder than surrounding talk.

'softly

Degree signs are used to mark speech that is much quieter than surrounding talk.

((sniff))

Double parentheses designate descriptions, rather than transcriptions.

(0.5)

Parentheses around a number mark silences in seconds and tenths of seconds.

We:::ll

Colons indicate that the immediately prior syllable is prolonged.

But-

A hyphen marks an abrupt cut-off point in the production of the immediately prior syllable.

(word)

Single parentheses with words in them offer candidate hearings of unintelligible items.

(.)

Parentheses around a period indicate a pause of one-tenth of one second.

.hh, hh

These are breathing and laughter indicators. A period followed by 'hh's' marks an inhalation. The 'hh's' alone stand for expiration. The '.eh-heh-heh' and '.engh-hengh' are laughter syllables (inhaled when preceded by a period.

NOTES

1. Other factors associated with variation in directive forms were 'territorial location, difficulty of task, whether or not a duty is normally expected [and] whether or not non-compliance is likely' (Ervin-Tripp, 1976: 25).

2. Two physicians in this collection are in their late thirties and are not residents. One is an alumnus of the training program who still sees patients at the clinic after completing his residency. The other is a faculty member who trains residents. In the analyses that follow, I find no differences between their directives to patients and those of the residents.

3. The patient involved in excerpt 11 is a diabetic whose blood sugar level was somewhat higher than usual on the occasion of this visit. Some people with diabetes can test their urine at home and follow their sugar levels themselves. But as this patient told her physician earlier in the encounter, 'th' sugar dudun' show up in my urine...Dat's why ah alweez haf tuh dipen' on the bloo:d' (Dyad 11:501-5).

4. Here, 'okay' can be seen as a mitigated response in that it affirms but does not explicitly state the patient's willingness to comply with the physician's directive (in contrast to 'let's do that', 'we could do that' or the 'yes' that follows it).

5. Of these relatively aggravated forms, three out of four appeared in the course of a single interchange in which a man patient repeatedly interrupted his physician to...
dispute the wisdom of her advice (West, 1984a: 66–9). In these instances, the physician's escalation to more aggravated directive forms followed the onset of the patient's intrusions, and may have served to assert her right to be issuing directives in the first place.

6. The overall rate of compliance with women physicians' directives would have been higher, save for the patient discussed in note 5. His lack of agreement with his physician's directives and lack of responses to her directives constituted 58 percent of the 12 cases of non-compliance I observed.

REFERENCES


