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Cambridge University Press

4 Seminar on open coding

This chapter is not a discussion of research procedures as such, but is an extended illustration of open coding, with commentaries on particular instances of it. Again, readers who are eager to move directly to procedures should defer reading this chapter until later, although it is placed here because to most readers it should be useful to at least scan it, especially the analytic commentary in its closing pages.

The chapter consists of one case: a research seminar session which was recorded on tape. The format of the presentation is this: first, a short introduction to the case; second, the analytic discussion itself; third, an analytic summary, with a detailed commentary on each phase of that unfolding discussion.

In the long extended case, the seminar participants are seen working together on the very real data of a researcher–student. By contrast, the pain-theory case in Chapter 2 illustrated a very active teacher, at a very early session of the seminar, "getting across" various elements of grounded theory methodology, using not a presenting student's data but only the combined experiential data of himself and the class participants. Here, while experiential data come visibly into play as an element of the analysis, the chief data are not collective data. Besides, there is the additional, if invisible, drama of a presenting student who is deeply concerned about the outcome – the product – of the class discussion.

Of course, the materials in this chapter are designed not only to illustrate the teaching–learning of analysis within the seminar setting, but to clarify further how qualitative analysis, especially open coding, is carried out in the grounded theory style of analysis. (For a further look at teaching it, see Chapter 14.)

Case

This seminar session – the participants are graduate students in sociology – had a specific purpose: to explore for the presenter (A.C.) aspects of interview

data that she had not focused on, thus expanding the possible scope of her future analyses. She would not necessarily be committed to the lines of inquiry explored in the seminar, but would follow through only on those that turned out to fit her data best, and with seemingly greatest exploratory power.

The student had interviewed several women diagnosed as possibly or actually having dysplasia (a form of cancer of the cervix). As is usual, the presenting student is able to supply useful or necessary background information at certain junctures in the seminar discussion; while other students are able to draw upon their own relevant experiences and sometimes on experiences comparable to those of the interviewee. The instructor (A.S.) opted for close examination of the interview data, but not necessarily for a focus on each line examined sequentially: So, he will be seen here directing the seminar's attention to selected lines and paragraphs in the opening pages of the presented interview, selecting them so as to bring out potentially interesting features of the data.

In this particular session, the instructor was especially active, "talkative," doing much of the actual analysis, though sometimes taking his cues from students' remarks and insights. He chose this style both because he wished to cover maximum ground for the presenting student and because at this point in the class development (about seven months of training) the participants were judged able to follow his (or their) techniques of dimensionalizing, utilizing comparative analyses, and to slip easily into the line-by-line mode of analysis. So, this seminar discussion, as it developed, illustrated for the class the rapidity with which diverse lines of inquiry, generative questions, and initial categories could be developed even from the first pages of a single interview.

For the reader of this text, other points are especially worth noting:

The use of experiential data by the participants;
The use of the interviewee's terms to form in vivo categories;
The coining of provisional terms to form other categories;
The posing of directing questions by the instructor, for various purposes: to keep the analytic discussion from wandering, keeping it on target; to force attention on the potential meaning of certain lines or terms in the interview; to push the students' thinking further in specific analytic discussions; etc. The instructor chose not to explore any category, or any dimensions, in much depth, in view of the presenter's request for expanded scope of her analysis;
The instructor assumed that: (1) more areas of exploration were desirable, rather than fewer in depth; (2) the student herself could add greatly to the analytic depth and she would do so if analysis of further data warranted it for any given category or dimension.

Other points are brought out in the detailed commentary which follows this text.

As the student herself later stated, the analytic discussion in this session "skimmed along and captured the tops of important waves." Later, too, she found herself following through on many of the main lines of inquiry and categories developed through the discussion. In the discussion below, the various students are indicated by M. for male and F. for female.

Phase 1

1. A.C.: This is my Dysplasia Study – the first time that the seminar is going to work on it.
2. A.S.: I think we need about five minutes to scan the interview. So why don't we scan it.
3. Apropos of this data, let me first give you a rule of thumb. If you know an area, have some experience, as I have said before, you don't tear it out of your head. You can use it. Now, with things like illness, we've all had a fair amount of experience, alas, either ourselves or somebody else's. So we can talk about the properties of the illness, and about the properties of signs of the illness – that is, the symptoms. Or we can talk about the properties of the regimen. Without even reading one interview. In other words, we have plenty of information in our heads about symptoms, diseases, and regimens. We don't know about this particular illness. But by dint of reading the first page of this interview, we can begin to make some guesses about the properties of each of those kinds of things. And so, let us just start out.
4. Now, your response is somewhat biased because of already having read the interview, but you can do the task. For example, diabetes, with its regimen – we all know about the regimen. It involves daily work, it's complicated, it involves more than one person, you know, and so on. And the symptoms: We know a little bit about them. The symptoms go all the way from catastrophic shock to havine urine show too much sugar, and so on. And the nature of the disease – but let that go, you get the general idea. Diabetes can be, for example, terminal. In the sense that you can pop off quickly – in crisis. But, you know that some diseases are terminal, some are not. You mention you've got a disease and somebody says "What's that?" You mention that you've got cancer and everybody knows what that is and what that means. That's as public as childbirth: Everybody knows about it and there are stories about it.
5. So, if we take just the face sheet and the first page and work on them, you can see some interesting things. For example: I'll give you a few points to get you moving – that it's cancer, therefore it's a touch of the terminal – it's got all the public imagery of that. Then, there's a question about whether it's treatable and how long you can keep terminality away, with all the remissions and so on. Or, is it a one-time thing, and they can get rid of it? Okay? And then the diagnostic stuff seems to be really brought out. You'll notice the first page doesn't tell you very much about treatment, except for the one paragraph which we get to in the middle. The diagnostic line makes clear that the diagnosis is uncertain. It can come as a surprise to the patient. There could be mistakes in it, undoubtedly. It doesn't say that, but we could guess there might be. And there's a question as to whether this kind of diagnosis is new or old to the patient. Has the patient had experience with diagnostic procedures like this, or is it a new kind of experience? Most of us have been through x-ray tests for example, but maybe very few of you have been through this kind of business. Pap smears are probably pretty common. For most women nowadays, this is so. Now if you consider next the symptoms – I don't know – are there any symptoms in this illness?
6. A.C.: Not at the dysplasia stage. No.
7. A.S.: See, so it's really fascinating. And in terms of the regimen, notice that it's solely in the hands of the medical professions. The woman doesn't do anything. It's one of the most passive things you can imagine except to get to the doctor. In other words, the question about how long does it go on – my guess would have been they would do the treatment right away – bingo! It's over. The interview shows something different. But, you know, regimens can go on for a lifetime or two months, and so on. The amount of money it costs is another dimension of the regimen. And so on. So, you can begin to kind of lay these kinds of issues out ahead of time. This already begins to raise questions, if you want to, even before the first interview; or they'll come out in the first interview. About, you know, what are the attractions, what are the experiences of people in this? So, for example, you could know ahead of time: They have a lot of Pap smears and then suddenly one shows cancer – you can just imagine what happens. If there were symptoms that preceded it, it might not be such a surprise: But there are no symptoms!
8. The exact analogue of this is that somebody goes in with a broken leg, and they do a blood-pressure test, and they ask: "Did you know you have high blood pressure? Hypertension?" Some people don't even know what that is. They have to have it explained to them. They see no symptoms. That is a complete surprise. To some, that can be pretty upsetting. Others don't know what it is all about – but it is hard to conceive of any women who would not know what cervical cancer meant. Though it could be; there might be some variation in response.
9. Anyway, in this kind of illness you can begin to guess beforehand what some of the reactions would be – some of the meanings, and all the rest. But again, you do comparative analysis to highlight this. Now, I'm ahead of you because I've been doing this for many years. On the other hand, as I've said, you've all had experience with various kinds of illnesses.

Phase 2

1. All right. Adele, what do you think the best way of handling this would be for you? What do you want to get out of the session today?

2. A.C.: I'm not sure whether it would be best to do it line by line or be more impressionistic. I mean, use both approaches. I don't know.
3. A.S.: What do you want to get out of it?
4. A.C.: I see certain things in the data already, and from hearing the next thirty pages of the first interview on the tape. But I would like to see what other people see, rather than me say what I've seen.
5. A.S.: To see if it comes out the same way?
6. A.C.: Yes.

Phase 3

1. A.S.: All right. Well, since she doesn't want it line by line, let's take it a third of a paragraph by a third of a paragraph. Let's start, say, halfway through the first page. What do the first four or five lines tell us?
2. F.: Well, that this had a beginning. It wasn't something there forever or . . . .
3. A.S.: What had a beginning: the illness or the discovery?
4. F.: It. The problem. Her cervix as a problem had a certain time to begin, and that was August, 1980. Although there is some confusion there, for some reason, about this very important date. And it was not a thing over which she had any control.
5. A.S.: What else?
6. M.: There was a break in a routine aspect of life. You go in and you do this thing and you expect nothing to happen. And you go in and do it and expect nothing to happen and then there's a break.
7. A.S.: And do you want to give it a word?
8. M.: No.
9. M.: Nothing comes to mind.
10. M.: Crisis?
11. M.: A break?
12. A.S.: It's a routine diagnosis. Right? In other words, this tells you right away that it's something you keep going in for; you know, at regular intervals. It's a routine, relatively scheduled diagnosis. There are very few diseases that are like that. Well, that isn't true – you go in for regular checks of your teeth. What else?
13. F.: TB tests, every year.
14. M.: Yes, if you go to school here.
15. M.: Blood pressure every time you go in to see a doctor.
16. M.: People get x-rayed every now and then – chest x-ray.
17. A.S.: But there's an interesting feature to this. I, myself, go for a check every month or two on my heart; now three months, maybe later, five months. That's a routine, diagnostic, scheduled check. But there's something behind it. Whereas *here* there's nothing behind it – behind it in the sense that I have an ongoing disease and I'm having a routine check about it. But here, there's no disease. But it's still a routine check. So there is . . . . What's the matter?
18. M.: Well, when you go in for your teeth, it's with the understanding that there might be a problem. It's really a preventive process. So, it's the same kind of thing?
19. A.S.: Yes. The dental thing is like that. But when I go in for my routine check for my heart . . . .
20. M.: Oh. I thought you made the statement that you were . . . .
21. A.S.: No. In other words, with an ongoing disease, even if the disease has vanished, so to speak, but is repeatable, it's returnable; there's a difference between that and a dental check. All right, let's take the dental check. What you have is a routine, scheduled diagnostic. But no disease experience behind it. So we've already made distinctions between routine diagnostic scheduled and the nonroutine. And obviously there are other nonroutines. You've got a symptom and somebody checks it out. That's quite different. So this is a symptomless . . . you ask yourself, how is it you have this scheduled, routine, diagnostic check when there are no symptoms and no disease? What's it all about?
22. F.: It's similar to having your teeth checked, because it's preventive, but it's qualitatively different, because you know that the chances are, the percentage, or whatever is probably going to be less. Most people have cavities when they go in and have their teeth checked.
23. A.S.: Just what do you mean, "chances"?
24. M.: It's a bigger risk. If something goes wrong with this exam, it's potentially more damaging than if you need a tooth repaired.
25. A.S.: We already know this is a high risk. We know that's the nature of cancer. But *chances*: What does that mean?
26. F.: It means that you can't do anything about it?
27. A.S.: Do anything about what?
28. F.: Whether you're going to have the cancer or not. I mean, your teeth, you can do more than having them checked up. You can brush them and, you know, not eat sweets and all that.
29. A.S.: That simply means that you are active in the preventive treatment.
30. F.: Right.
31. A.S.: So there is a difference between the onset of the business. Some, the person can prevent some; and some not. I thought you used chances in another way. Why chances, for this scheduled, routine diagnostic?
32. M.: It's against the risk that there might be something wrong. But the risk that there might be something wrong, in this case, is a lot less than the risk that there might be something wrong in a dental exam.
33. A.S.: What's fascinating about this is that the developments of dental cavities are riskier, in terms of statistical probability. On the other hand, once the problem really confronts you, you'd rather have

cavities than symptoms of cancer. Anyway, you're playing a statistical game here. So there's some sort of – whatever word you coin for it, this is a diagnostic procedure that has to do with probability.

34. F.: I think that's people's experience of it. That most women go for Pap smears all the time and absolutely don't expect when they go that anything's going to be wrong.

35. F.: Something you do every once in a while.

36. A.S.: We'll come to that in a minute. But let's take the other part first. First of all, there's the statistical game, probability. The other is that if it's caught or not caught, there are degrees of fate. That will come out in the interviews, because some women will tell you that they skipped for ten months when they shouldn't have, and then they got hit. "Why did I play with fate?" If you could predict that. All right, now we come to what Gayle has pointed out. Say it again.

37. G.: Well, because of the regularity, because of the scheduling, it just becomes a sort of stage in your life, something you just do, maybe like going to the dentist (but the experience is so different, I don't want to compare it) – you come, after a while, to actually believe that nothing will be wrong. And that's the assumption under which you go; you don't schedule any extra time for it, you don't think I'm going to need extra time after I go today because I might need to recover from what it's like to do this. You just do it. It takes minutes.

38. A.S.: Lots of people go to the doctor for an annual checkup, really not expecting anything. So, you have a distinction now between checkups – with more or less degree of expectation of something going wrong.

39. F.: I think it's interesting – and it comes out in these very first few sentences – Adele asks: "You went for a regular physical?" No, she didn't. Women don't do that all the time. But they always go and get a Pap smear. I mean, that's medical habit. That's been institutionalized in this society. You get a Pap smear.

40. A.S.: But can't you imagine a variation? Imagine some woman having read about this cervical stuff, you know, a couple of weeks before she's scheduled. Then she might go on – there are some people who would then be apprehensive. "You mean it's twenty-five percent?" You know, whatever, something like that; or let's say your best girlfriend has just come back from a "bad" diagnosis and you're coming up yourself. You might, then, even speed up your schedule. So, it's mostly routine, like an annual checkup or a dental thing, but you can suspect there might be variations that a routine becomes nonroutine, psychologically, let's say.

42. A.S.: So that's – let's call that the diagnostic durational span – something like that. How much time in between? Two days ago somebody said to me that his spouse is going for a check – his spouse had a mastectomy a while back – his wife had another lump. And I said: "When will you know?" And he said, "In about a week." I said: "What! You should know within twenty to thirty minutes. Get on it." He said: "You don't know Kaiser." I said: "I don't give a damn, if you curse like hell." Well, it turned out to be benign. It turned out that they did the test (and it's ninety-seven to ninety-eight percent accurate usually), and it's OK. So that durational business is a – especially when there's a fatal disease, is fantastic. So that's not only an element in the interviews, but it's part of the analytic picture. Now, what else?

43. F.: Another part of this experience that I would think of before I even read this (about what the circumstances are under which this could lead to the dysplasia) are the issues about how you're treated when you go for this kind of examination. Most women have lists of experiences in their lives about being treated in terrible ways when they go for Pap smears and any other kinds of gynecological examinations. And it turns out later that she has had such experiences. Before I even read them I thought, you know, Who's going to shit on her? Who's going to do some unreal, unbelievable thing during the course of her going in even for these things? no matter what happens. . . .

44. A.S.: You're running ahead of the story, you're reading ahead of the data. I had that down on my list, but decided to hold it: that one aspect of diagnosis is, it is done by medical people. And you can ask about the medical ways of doing this particular diagnosis. But that obviously varies a very great deal in different kinds of diagnostic procedures. Even if they're all medical. OK? But it will also make a difference if it's a small town where you know people and "U.C.," where you don't. You could foresee some of this ahead of time. Hold that point, because it does appear later.

Phase 4

1. A.S.: Now, let's do the next four or five lines: "Actually, I normally go every six months because I have herpes," suggests that she knows there's some statistical probability that of an increase because of the herpes. So maybe that people with herpes – in terms of the variation of the population – people with herpes should be more expectant of their high probabilities of having cancer, than people without it.

2. F.: I think the regular routine, normal and abnormal – you know, it's almost in every line there of the first seven or eight lines: "I normally go," "I usually do," "I . . . ," and so on. "This is the first time I'm abnormal." So there you have a little – I don't know what abnormal is and I don't know what normal is, and what the terms mean to her. If it's normal, then you just don't worry about it; you don't do anything; and you don't really know what normal is, except it's not a problem – nobody says it's a problem.

Then, all of a sudden, you've got to define *abnormal* – I mean, you didn't have to do anything about *normal*; but when you find abnormal, and all the way to, I mean, she's putting this . . .

3. A.S.: That's very good that you've picked normal/abnormal; but, if you just don't take the line – "It was the first time I had an abnormal, all the way down to three" – think of the difference comparatively of when you go to a doctor and he does an EKG on you, let's say. He will give *you* the information about what it means, what it might mean – very specifically. Or you have an annual checkup and he discovers something. And he says, "Look, you've got anemia. You don't feel it, but you have it. Well, a touch of it. Better do this now." And he gives you pills. Nice, clear diagnostic. Here, it's not only ambiguous, but the patient is thrown back on herself, in a certain sense, to interpret it. So you have the patient's interpretation of diagnosis.
4. F.: But it's masked by all these elaborate medical categories. And each place has a different category system of terms. But even here, when she says "all the way to a three," she already had to learn the system that they have imposed on this to make that statement meaningful to her. They told her she has a *three* – what does that mean? It doesn't mean anything. She had to learn the major difference between a *two* and a *three* or a *two-and-a-half*.
5. F.: Although you don't really know what they actually told her.
6. F.: They're really ambiguous, but they're faking the diagnosis, by pretending with this elaborate, precise, quantitative-sounding system.
7. F.: But I had a question about that because she seems to know a lot about what these twos and threes and all that mean, and I was wondering if she knew that before . . . .
8. A.C.: Yes, that's what I said at the top of the interview. She was a para-, worked as a paraprofessional in a family-planning clinic, so she had some health background.
9. F.: So we don't really know what they told her. And if she's a paraprofessional, they may actually have told her what it meant, and then she uses it, too.
10. A.C.: I think she likely knew what it meant before, because she was already aware that herpes is associated with it.
11. A.S.: That gets into variations. Some people know it and some of them don't. That's built in. You don't have to worry about the absolute truth of this particular lady.

Phase 5

1. A.S.: I think "all the way" is an interesting phrase. I mean when you talk about "all the way" you talk about completion of the sex act, you talk about "he made it to the top," all those kinds of things. So here she's using her diagnosis and the fact that it came back

abnormal to indicate it has reached a certain definitive kind of stage. That's a dire way of talking: "All the way" – as far as a diagnosis of dysplasia is concerned.

2. And then, what do you do when you find a bad diagnosis like that? You immediately look for a second opinion – which is just what she did. First she "freaked out," and then evidently she began to think about it, and went right back down to somebody else to get an opinion, and then another opinion. So she's really checking out what resources are available: to have gone all the way to a three.
3. F.: I think there is also surprise there that it wasn't more gradual. It was the first time and it was already more than a two all the way to a three. It's like she goes every six months; she should have had a one, then she should have had a one-and-a-half.
4. A.S.: What does the phrase "all the way" mean? Converted, coded? "It was more than a two and all the way to a three." If it came from zero. Right?
5. M.: An extreme development.
6. A.S.: Right. Extreme development along a continuum – and what is the continuum?
7. F.: Noncancer and cancer?
8. A.S.: You can't say noncancer and cancer. It's a continuum of from zero to catastrophic. So, it's a disease continuum. If I have a bad back, I can say, "Well, it's not so bad, it's mild." Or I could say, "It's killing me." That's a symptom continuum. So I have words for both. OK? Here, they're not talking about symptoms, they are talking the disease itself. Well, they're symptoms – but they're invisible to the patient.
9. The other thing that is startling about this is – well, I'll give you the counterexample. When I had my episode in the hospital last October, the doctor, after I got out, did not tell me how bad he thought it was. I totally surprised him by doing far, far, far, far better than he ever expected. But he didn't tell me. It wasn't until months later when I asked him to tell me what he really had thought back in October. But here, they're telling: "You've got a three." So what do you want to do about that one? If you have a tooth cavity, the dentist tells you, doesn't he? He says, "It's bad enough. I think we'd better keep an eye on it. Maybe next time, we'll do something about it."
10. M.: Why are we considering the results of a test on a disease and not the symptom? Isn't it just a symptom made manifest?
11. A.S.: I say it's a disease continuum.
12. M.: Carcinoma is on a continuum: carcinoma in situ and long-term carcinoma.
13. M.: The results of the test, though, could show that a disease will occur or won't occur.
14. A.C.: In this disease? No. All the tests can tell you is whether the cells that are there now fit into a normal range or varying ranges of abnormal: "Today."

15. M.: But even if they vary into the abnormal range, it does not necessarily mean that the person will have the disease. Or is that itself a disease?
16. A.C.: That, well, it does mean that dysplasia is a disease. Because it has a, yes . . . . But it can remit. I mean, that's where, that's what the weird part . . . .
17. A.S.: But we haven't talked about remission. Hold the remission . . . .
18. M.: Then I have a problem, too, because if you say that, then, why isn't back pain a disease, rather than a symptom?
19. A.S.: If I have diabetes – OK? – and I begin feeling really badly; and my tests show that I'm in bad shape; I may even go into the hospital for a few days, if they put me back. On a continuum of symptoms, the symptoms are obviously much more severe. I know it. And if you want to say, well, all right, the disease is more severe; but the doctors wouldn't really talk that way; they'd say, "It's acute now." Yet, they don't really mean it's any worse than it was. You can here blur this symptomatic thing and the disease, but it's clear that with dysplasia the symptoms are not visible to the patient. But, the doctors are talking about a disease continuum, that is what it is.
20. M.: I think that one part of the continuum is very nebulous – what they are talking about. It could mean nothing. And on the other hand, it means cancer straight out.
21. A.S.: If it's up in the upper regions diagnostically, that's cancer. So, what you want to talk about when you talk about the disease continuum is that, in fact, the upper regions of it are nonambiguous; but the lower regions are ambiguous. That gives us a distinction. All right: How are we doing?
22. F.: Of the disease diagnosis?
23. A.S.: Of the disease diagnosis.
24. F.: But not of the symptom diagnosis.
25. A.S.: Yes. Then we come back to the business of telling or not telling. This is a direct telling. Isn't it? [Pause.] A very direct telling, but it's a direct telling of exactly what the physicians know, or suspect. Sometimes they'll say you've got cancer; but they won't tell you how bad it is, which is very usual. But here they are telling her – directly. So, there is something very, very different about this announcement. So, let us call this a *diagnostic announcement*. OK? And there is no withholding of information. (This is the whole "awareness context" business that Barney Glaser and I talk about in the *Dying* books.)

Phase 6

1. F.: Did you ask, at that time when she said, "all the way to three" whether what had gone on between her and whoever did the Pap

or whoever reported to her? What information she had available at the time? I mean . . . .
2. A.C.: Well, she tells you about that later in the section you have. That she found this first diagnostic, and that it was in her home, by a friend who worked in the place where they do their diagnoses, and sat down and talked with her about it.
3. F.: This first one was in "U.C."? I know the first one was not done there, but this one that we're talking about – "all the way towards three" – Was that the one that was done in Ukiah?
4. A.C.: Yes.
5. F.: Well, that was a warm, friendly clinic, so she should have had somebody there; at that time, did she talk to somebody about becoming a three, and . . .
6. A.C.: Yes. She says that later on.
7. F.: . . . and that was the assurance, that, "It may not be anything," and so on?
8. A.C.: Yes.
9. "And the person who told me my Pap smear was weird was a friend of mine and she told me when she came to my party and was very sensitive and nice about it, and told me not to worry, it could be anything."
10. A.S.: Before we go to the last third of this page, the phrase – "freaked out" – by the way, she's given you . . .
11. M.: An in vivo code.
12. A.S.: She's given you an in vivo code. This is a category stemming from a class of responses – "freaking out." Which clearly has to do with: What are the conditions for "freaking out" here? Well, the imagery of cancer. That is, terminality. And surprise. You don't freak out when it's fed to you in small doses, or you begin to suspect it, yourself, before the diagnosis.

Phase 7

1. Now, the last five or six lines. "So they referred me to U.C." Now, what is that all about?
2. M.: There are some places out there that just tell you the information and some places that do something more about it. You've got to go around, you can't be taken care of in one place.
3. F.: It kind of looks like there is a career that you go through – I mean, she did have something definitely wrong. But that isn't the end of it, there. Then you go somewhere else and this keeps building up until you finally . . .
4. A.S.: Let's do this comparatively. Let's say that you have a very strange disease. For example, I know someone who had lead poisoning and nobody diagnosed it, although she went to dozens of doctors. Finally, by accident, she happened to talk to an English doctor who was an expert on this, who was [illegible]

she. He said, "My God," and he gave her tests, and she had lead poisoning. So, it took her three years to find out that she had lead poisoning and she went through a lot of doctors, and had a lot of tests. So, *diagnostic career* is your word and it's absolutely right. But sometimes you don't have a diagnostic career. As when, if you drop in at the doctor's and he says, "My God, you have cancer," on a routine test. Or, you have one symptom, and they put you on an EKG and you've got heart problems. There's no career at all. The referral business from the G.P. or the internist to the specialist is a very short diagnostic career. Bang, bang – it's finished. But here you have a diagnostic career, which seems to have more direction. And it is more complex and has more steps in it.

5. F.: Isn't the reason that you have that kind of career because the test itself is inherently ambiguous?
6. A.S.: Under what conditions will you have a longer diagnostic career? Well, severe disease; or, if you are in the wrong place and people aren't very experienced in detecting it; or, it's ambiguous. Now, if this were not a very serious disease, they wouldn't send you to six different doctors or four different clinics.
7. So, the conditions for this diagnostic career are clear – some of them. The consequences begin to show up later in the interview; the consequences of having a long diagnostic career combined with a dread disease . . . . What else is in these few sentences?

Phase 8

1. F.: But after you go to all these different doctors and you're supposedly trying to get a more precise statement from them, you get a statement like, "It looks a little weird," which is a colloquial expression – it's not medical language; it's not a specific statement; it's not precise in the slightest. Aside from this whole thing of having no compassion, it's . . . .
2. F.: I was wondering about that . . . .
3. F.: . . . "Gee, it looks a little weird."
4. F.: . . . talking about lumps and weird: Is that *her* terminology, or is that what they actually said to her? I can't imagine . . .
5. F.: She used "weird" earlier, so I think it's her term . . .
6. F.: . . . her way of saying, interpreting what he or she said.
7. F.: Really? I thought that was what . . .
8. A.C.: Well, it may be. I will have to ask her.
9. M.: On the last page, where that same person, I guess, is clipping away, trying to get tissue to examine, probably it means that they want to do a further test to find out, so it won't be weird. We don't know that for sure. It's just . .
10. F.: And then I thought that in the last section she was getting a little – I mean, she says, "The doctor was just wanting to cut away."

That's kind of a – I think that goes with "weird" and "lump" and that sort of thing, that kind of terminology.

11. M.: Well, "D&C" – it's like it's a rationale for further testing, further procedures.
12. A.S.: The main point is not "weird." "Weird simply means that they've discovered a diagnostic sign which alarms everybody. So she could be high up on the disease continuum. So what you should be focused on is not the weirdness – that's simply another way of saying she's high up.
13. F.: That's like that the doctor told her that she didn't know what it was.
14. A.S.: But that simply means that the ambiguity goes on.
15. F.: Right. But the doctor could not have told her that. I mean, the doctor could . . . .
16. A.S.: Did not have to tell her. The doctors are still telling her "We don't know" – but it might be dangerous. It's still going on, just like it did in the beginning. So there's a repetition of that. So, the diagnostic career consists of a series of diagnostic steps. It isn't that she's just going from clinic to clinic and doctor to doctor, it's that each person is doing something additional. Right? And so, what I am saying – convert it analytically.
17. M.: Progression? Different stages in treatment?
18. A.S.: No, we're not talking about treatment; we're still talking about . . .
19. M.: Diagnosis. But there are stages there.
20. A.S.: Right. So the diagnostic business is in stages – or, if you want, cumulative, or whatever language you want to use. In other words, they're adding tests, so the tests are done sequentially. First, they do one, and then they do another one. They may repeat – but they do other kinds. Now when they did this other kind – that is, when they examined the uterus – they didn't, the first time. Now they examine the uterus; now they discover, what? Another diagnostic sign. This is common sense: It is hard to see it analytically. The fact is, the additional diagnostic test is supposed to show additional diagnostic signs which might have been missed by not using such a fine test, or such a supplementary test. Right? That's what it's all about. When they give you a CAT scanner after an x-ray, they're looking for new signs that were missed by the old test – or couldn't be shown up on the old one. But there are diagnoses that aren't like that. Although this is pretty common in the medical business. But, say, if she had the Pap smear and it showed up as potentially dangerous, then she should have been ready for somebody to say, "Well, the uterus is cancerous," or "the uterus is" something. So she shouldn't have been that totally surprised. But she was. You know, variations in responses are possible.
21. A.C.: Those two phenomena of a bad Pap and a lump can be found very independently. They're not necessarily linked at all.

22. A.S.: Sure. But what I'm saying is that on the face of it, somebody shouldn't be so surprised: having a three and now to find something wrong with the uterus.
23. F.: Except that forty percent of the women – at least those over forty years old – have a lump in their uterus anyway, a fibroid.
24. A.S.: Do they know that?
25. F.: Well, if she's a paraprofessional and she worked at Planned Parenthood, she should.
26. F.: But she's not forty years old, either.

Phase 9

1. F.: You know, what's interesting here to me is, alongside of the career of the diagnosing of the disease, is Goffman's "cooling the mark out." What does that mean to that patient's concept of herself as a patient? I mean, she is increasingly becoming committed to patienthood as a possibility for her – a cancer patient.
2. A.S.: You can't tell that from the first page. That will show up later, maybe. You can't tell that from the first page, can you? I think you're right. It's going to show up. What you're doing is perfectly right – you're making a memo to yourself – "this is a possibility." But, you can't count on it yet, not from this data. It's perfectly permissible, as you know, to write a memo to yourself, to remind yourself to look for it on the next page of the interview.

Phase 10

1. All right, let's move on. The business about the "compassion" and so on is so obvious that I don't think you have to tell Adele about that . . . . Let's take half of the next page. The question here is: What is this paragraph mostly about?
2. M.: It's a comparison. It's a comparison between her city experience and her country experience.
3. F.: In terms of interaction.
4. A.S.: In terms of what?
5. M.: In terms of the interaction with the people who were treating her.
6. A.S.: That's OK. But it's a little crude. What is the interaction really all about? The interaction is humane in one place and impersonal in another. But what is the interaction all about?
7. F.: If she's not sick, it's a comparison. She could be fine. The whole rest of the thing, her saying that she was . . . .
8. A.S.: We already know that it could be ambiguous and all that. But what is the interaction about?
9. M.: The diagnosis. No?

10. A.S.: Well, let me put it this way. What has her friend said to her? Initially. Let's take it step by step. "And the person who told me" – which is about five lines down – "is a friend of mine." "And the person who told me my Pap smear was weird . . . ." And then she gives you the property of the person who told her: ". . . was a friend of mine." And then she tells you how she told it. So she's telling us: She told me. The person who told me had this property. And the interaction had this property. And who told me my Pap smear was weird? What does she say? What is that interaction?
11. F.: Well, those are different strategies of doing the same kind of thing.
12. A.S.: Yes, but what is the "same kind of thing?"
13. F.: Breaking the news.
14. A.S.: Breaking the news. It's an announcement. This is a diagnostic announcement. "Adele, I'm glad to tell you that your symptoms mean absolutely nothing. It'll go away in a week. Just leave it alone. Don't do anything." That's an announcement.
15. F.: Also telling her what to do about it.
16. A.S.: We'll hold that for a minute. Just plain announcement of what the diagnosis is. So that has various properties, if you stop and think about it. We don't have to spell them out – Adele can do that. Think comparatively. It can be gentle, it can be severe, it could be surprising, etc., etc. *You* work it out . . . . Then the woman gives you properties of the announcer: stranger, friend, acquaintance. But the real emphasis, obviously, is the way it was told. Adele can surely handle that.
17. Now, at each one of these places along the diagnostic career, somebody's going to make an announcement. And the announcers get to be more and more strangers, as they get further out. And they tell in different kinds of ways, with different kinds of consequences. Notice, the consequences here are not the consequences of where it is on the continuum, but the consequences of the way it's told. And you can see this comparatively. If somebody just tells you, "Look, I'm afraid you're going to die in six months"; or somebody puts his arm around you and says, "I just hate to tell you something. You'd better brace yourself. You've got about six months to live" – it might not make any difference – six months is six months. But it may make a big difference. Right? And this is what she's getting. She's talking about the quality of imparting the information to her.

Phase 11

1. A.S.: There are some other things like she sends this woman along the diagnostic path, career.

2. F.: And you could call Ukiah and U.C. and General Hospital in San Francisco *medical stations*.
3. A.C.: I should like to make one thing clear. It wasn't that she was coming to the city only for diagnosis. She was going to law school in the city and her husband was in Ukiah. So she would commute to Ukiah. I mean, she was living in two places, so she wasn't . . . . In other words, if she had been living in Ukiah, she may well have ended up at U.C. But it might not have been so rapid.
4. F.: Except that when she freaked out, she immediately went to another medical station, another place, for a second opinion. And I think she would have done that whether she was living in two places or not. Wouldn't she?
5. A.C.: I think she might have repeated the Pap very quickly, but not necessarily in a different place. But I think your point is well taken anyway, you know, the medical stations.

Phase 12

1. A.S.: What about the last two lines? "Get another one right away, within two or three weeks." What's that? Convert that analytically.
2. F.: Although I have been very gentle about this and given this information in the nicest way, nevertheless it is urgent that you attend to it and do something about it. It's still a serious . . .
3. A.S.: So the doctor is giving a diagnostic directive: Get another one. She's moving along the diagnostic career path. She's giving a directive. A directive, in this case, is not where to go, but how quickly to do it. A directive could be various kinds of things: Go here; go anywhere, but do it right away, etc., etc.
4. M.: Also, the way the person interpreted it: "She asked me to follow up on it." She didn't say, "You've got to go tomorrow and get another one." It was less of an imperative. More – leaving more control in the hands of the person on whom that diagnosis had been done.
5. A.S.: Scheduling, then; the duration of time between now and the next diagnosis; as a terminal day: two or three weeks. She's not pushing her to do it right away. It's not like a doctor saying, "OK, would you please go down and get an x-ray right now? It's in the same building."
6. M.: It may be a difference in the way it's told to her, because they're friends.
7. F.: Right. Like I had a friend with cancer of the prostate and another friend who was a radiologist. And the friend with the cancer of the prostate – who was young – wanted to know what his chances were. And what was involved in the radiology. So, I called the radiologist and an oncologist and talked to them. Well, the radiologist was a good friend and he said to me: "What difference does it make? If it's positive and he's got cancer of the prostate and it has metastasized, what are you going to gain by giving him all this information right now, as his friend? Let him have his weekend free. Don't give him all the bad, bad possibilities. Let him find this out from the doctor. Because, one way or another, it's going to happen, but why do you have to be the one?" It seems like there's a similarity in letting down gently or have it taken care of, but not kill him off right away.
8. A.S.: Yes, but what are you talking about? In the first place, who gives the announcement? The doctor? The nurse? But there's also the question of the timing of it. The doctor knows, for example, you have cancer – right away. But he'll wait a week to tell you; and he'll feed it to you gradually before the real announcement. He wants to put it in the general way, first. But notice what I did: I took your phrasing and I split it in two.

Phase 13

1. I want to stop here a minute and give you a comparative example, and give you an analysis along similar lines here. I go to New York with my wife. (I'm going to narrate the story just to give you the general idea.) My sister-in-law is having angina. She goes to the doctor, who says to her: "There are changes in your EKG. You might have to have a bypass. Maybe. Someday. No urgency." He sets up the next diagnostic test, it's a stress EKG test, for three weeks later. Here, we're seeing her only one week later. And I say, "That's ridiculous. Speed it up. It makes no sense. I don't care how crowded the diagnostic lab is." She drags her feet. Two days later she has a lot of angina. She calls her doctor. The doctor gives another EKG. It's bad. He sends her to a cardiologist, who orders a stress test the next day. The day after that, they do an angiogram. The angiogram says you have to have a bypass or live as a cardiac cripple at home. She has the bypass. All right: You hear the same language about a different disease, different kinds of pacing, and so on. Now do a quick analysis of that, in terms of the concepts that we have developed. Let Adele try it. Some of it. Just do it crudely.
2. A.C.: Well, we have the diagnostic career and the patient career running alongside one another. In terms of the diagnostic career there is a moderate revelation. You know, that yes, there's something wrong, but don't worry about it, and you'll have this other test coming up along the line. And then in terms of the patient career, there is an intervention or a change in her career with your arrival, provoking a reanalysis on the patient's part of her situation. In the return to the doctor and more decisive bad result . . .

3. A.S.: Speedy, rapid diagnostic work. Sure. Repacing of it.
4. F.: . . . narrowing down your diagnosis?
5. A.S.: But you're also getting additional information from increasingly sophisticated techniques.
6. F.: And you're also educating your patients.
7. A.S.: But also a key turning point is that the symptoms are also increasing. They're coming more quickly, every four or five days.
8. M.: In fact, the only language that doctors listen to is "symptoms."

Phase 14

1. A.S.: What about the "fitting" of the information to the patient? What does that look like?
2. F.: It seems to vary with the situation. I mean, if they think it's urgent, they'll lay it on you – heavily and quickly. But if they can avoid it, they won't. I mean that's how it strikes me from that story.
3. A.S.: The announcement about the real surgical bypass was very direct, in fact, graphic. They brought her diagrams, immediately after the angiogram, and started talking about what the options were. They were very clear. So, you know, talking about the properties of that particular announcement: were made under what circumstances – slow, muted, direct, etc., etc.? Anyhow: You can see how different this is. But one thing, it's up to the doctors to treat it. There isn't much you can do except go through with the operation.
4. F.: And then the whole thing also is a career in loss of self-control of the patient. I mean, at first when you go in you have a decision to make. And you can't. Increasingly you are overwhelmed by technology and tests and diagrams.
5. A.S.: Well, you have decisions right then, up to the moment they knock you out and put you into the operating room. Up to that point, you can opt to die, you can opt for medication instead, or you can opt to put it off for three weeks. There are lots of decisions you can still make. Ordinarily you don't. But until the point at which you make the decision and turn it over to the doctor, a lot of it is in your hands, unless you're weak or "out of it."
6. F.: I think there are junctures where, yes, you can make a decision to do *x*, *y*, or *z*, and even counter the doctor's recommendation, but there's something about the frame of that decision, and that the framing of it gets narrower or constrains the patient's experiential vision of alternatives.
7. A.S.: Well, let's give it a word, like *medical funnel* or something like that. I shouldn't give you these terms, you should make them up yourself. But you see how they're coined. I mean, essentially, the narrowing control – or whatever term you want to use. It doesn't

make a difference. Later on, if you don't like the word, you can change it. You've got to coin the words in order to cope and pin down exactly what you mean . . . . But you can see what the properties of the funnel are. How fast? Is it reversible? Is there really a funnel like that? How quickly? Etc., etc. How much of a funnel? Etc., etc.

Phase 15

1. A.S.: Do you see what I did? Having got as far as we did, I simply opened up another comparative example. To see whether the categories made any sense. But also, it now begins to tell you some of the differences. So that we can be even more aware of the niceties and some of the unique features of this particular diagnostic process. Maybe they are not totally unique, but certainly patterned in ways that are different than a lot of other diseases. And if A. wants to do it, she can just try it out a little bit on other kinds of diagnoses.

Phase 16

1. A.S.: I want to move quickly, now: that business of this lady telling her about the lump in the uterus. This is simply another example of announcement. Of another diagnostic sign. It might be cancer. You get the results of the Pap smear and they won't tell you what to do with it. It's simply a rather nasty way of saying what the next step to the diagnostic series will be. And again, the duration. The duration would be the diagnostic wait.
2. F.: How about the comparison of the lump and the pimple? I mean, she's doing something there, that kind of contrast.
3. A.S.: Where is that?
4. F.: About, "U.C. is extremely professional. I mean she might have been telling me I have a little pimple, and then she says I have a little lump in my uterus. A little pimple on your nose is the small end of things and the lump in the uterus is the big end of these things. And yet she's treating me like this great big thing is just really a little thing." I don't know how you would generalize this, but it seems to me that that contrast is something that you would want to think about.
5. A.S.: Let's use Hughes's distinction between some people's crises that are only routines to others. Maybe she's really not announcing this as a sign of real cancer. Maybe she's just saying, you've got a lump so we have to look at it. Possible. In a real interaction, that's what someone could be in a position to do. Find out.

Otherwise, *you* don't really know what the interaction is about. You only know the way the patient interpreted it.

6. M.: She sees it as a lack of concern on the part of her doctor.

Phase 17

1. A.S.: I want to move quickly because time is elapsing, and I think A. could get much of this by herself. The first half of the interview can be covered by the kinds of concepts we have now.
2. It isn't until the middle of the interview that you get anything new. And that has to do with prices. The properties of regimens. This particular one is not exhaustingly expensive, but it's pretty expensive. So you can play with the properties of that one, and the patient's responses. Variations of it – if it's $1,000, it's all taken care of by insurance.

Phase 18

1. A.S.: OK. Go to the bottom of the paragraph.
2. F.: The last paragraph? It seems to me there is a lack of fit between the patient career and the clinic, career of the clinic, pacing context in terms of the people rotating the doctors through.
3. A.S.: There are some funny things about the diagnostic process, the diagnostic career. Sometimes you see the same people, sometimes you don't see the same people, depending on circumstances.
4. F.: And for me that all seems to be, all part of pulling the patient apart – whether it's deliberate or not – you are then focusing on that clinical problem and what is presented to them.
5. A.S.: Well, if you do a study of the medical system at U.C., you'll probably discover that there wasn't anything deliberate about it; it's just that there is no system, in that different people do the different tests, do them in different parts of the hospital. So you're dealing with the structure of the test making.
6. F.: Yes, I think so. But there's also that the patient isn't really and truly as important. Like, I know a little leukemia patient, and he's had leukemia since he was two and he is now ten. And they want to do tests on him. The concern is not so much the patient as what they can learn, what they can gather together from his experience. And I wonder if these people rotating through, and so forth, if the patient role is different.
7. M.: You might have the same person all the time, you know, rather than different people doing the tests.
8. A.S.: Now look: What's going on here is that she's taking additional kinds of tests, right? So, structurally, in terms of the hospital,

sometimes the same people are going to do these different tests. For example: The same people who do an x-ray also do a scan. And sometimes, it's done in the same department, and sometimes it's not. Depending on the hospital. If they are going to do an echocardiogram, that's going to be in a different part of the hospital, different department. So, it looks like she's hitting different people because of the institutional structure. Gayle's point is well taken, in the general sense, that if you want to ask what the staff attitude and handling of this test is: That they're really concerned about this patient with leukemia, that's one thing; but just doing tests for the sake of the research effort – then the attraction is likely to be something different.

9. F.: But I think what she's saying, too, is that there is no communication between these people who are doing the different tests. So they're all, you know, atoms out in space with nothing keeping them together. Whereas . . . .
10. A.S.: That gets you into analysis of the structure of the hospital and the structure of test taking. What happens, if you want a picture of that, is that here's the doctor in the middle and there are bits of information funneling back to him or her. So you get a division of labor which is pointed to him or her, rather than their talking to each other. OK? There is no communication, unless there was an x-ray or a CAT scanner in the same department. But, under routine testing, they wouldn't bother talking to each other. So what you're talking about is a division of labor in the diagnostic process.
11. F.: But they could talk to each other if they made an effort. And I think that might make her feel better.
12. F.: The hospital assumes that communication occurs through the patient's records. That's the supposed vehicle.
13. A.S.: Look: If here you want to get into the structure of the hospital, the way it is done, it looks like this: Here's your patient. She's on the department's escalator. People coming through, in the course of the day, she's number 691. That's the way they're set up, to do x-rays. Now, what's the likelihood of their telling anybody about this unless it's exciting to them?
14. The analytic point is that the information is going this way and that way. And there are days in between. What's the likelihood of communication when their talk is this way, and not this way? It's only the person at the receiving end who gets the information.
15. M.: Is that the same person whom she can call her doctor: Is there a continuity of the doctor as well as the patient – or is it, you know, she goes to the clinic and she may see the person she saw before, or may not. And they may have the tests from previous times, and they may not.
16. A.S.: Now we're back to the announcement. If you have a doctor: Let's say, you go to a doctor because you have something wrong

with your heart. Then he sends you out for these tests. The angiogram guy doesn't talk to the stress guy. The stress guy doesn't talk to the other guy. These test results all will be funneled back to the cardiologist, who tells her. So, this has to do with the announcement. And how it is done. And the degree of severity, and the content, and so on, of the announcement.

17. F.: There might be a change between what goes on in the diagnostic process and the dividing up of the people and no communication, and what happens when she finally gets a definitive diagnosis and treatment. Frequently, you will find that, OK, you have a connection with all these people afterwards. You do get a network going. You do know the people in x-ray and the people who do your CAT scans and the people up in the unit, and so on. Even if they don't communicate with themselves, or with one another, you have a network going. I don't know whether that shows up.

18. A.C.: Not in the Dysplasia Clinic, if it is still organized the way it was then. Those people do a two- or three-month residency "training," or whatever they're doing.

19. F.: OK, that's the diagnostic stage. But when she gets her diagnosis and something happens, and she's treated – is it different then?

20. A.C.: Oh. There are supposedly two head doctors, one of those left during the process . . . . Later in the interview – I mean, it seems to be an extreme end of that continuum of continuity, where there's very little communication.

Analytic commentary

In the pages that follow, the class discussion reproduced above will be divided into sequential phases of development. Commentary is addressed to what is going on – in terms of analysis – during each phase. Points will be numbered 1, 2, etc., while the associated paragraphs or lines of text will be numbered within parentheses; (1), (2–3), (4–10), etc.

Phase 1

1. (1) Injunction to scan interview for five minutes.
2. (2) A rule of thumb: When you have experiential data at your command, in your head, don't ignore them. Use them. Here use them, via comparisons of different diseases, to sensitize yourself to features of this particular disease.
   (3) An example.
3. (4) First lines plus instructor's knowledge of cancer allow him to suggest dimensions of the disease (visibility, treatability, etc.).
   (5) Line in the interview about diagnosis raises questions about another dimension (certainty) of diagnosis.

   (6) Student gives relevant information.
   (7) Discussion of regimen duration, and statement that one can raise questions about a dimension like this even before reading the first interview (because of experiential data). Anyhow, the questions will be raised by reading the very first interview (example: re cancer).
   (8) Brief comparison with blood pressure: invisible symptoms and consequent surprise after diagnostic announcement.

Phase 2

1. (1) Question: What do you want to get from the discussion?
   (4–6) Student's response.

Phase 3

1. (1) Decision on lines of interview and directive to seminar.
2. (2–11) Focus on break in routine aspects of life expectation.
3. (3) Coining a term for category: routine scheduled diagnosis. This raises questions about other diagnoses for comparison.
   (13–16) Examples.
   (17) Cardiac comparison raises questions about routine, scheduled diagnostic check with or without disease.
4. (21) Routine versus nonroutine diagnostic check. Question: Why nonroutine check when there are no symptoms?
   (22–32) Answer: dimensions of risk; comparison with dental situation.
   (33–36) Risk probabilities.
5. (37) Student raises issue: routine checks and nonexpectation.
   (38) A.S.: a continuum.
   (40) Questions: the issues of variations?
6. (41) A.C.: Gives data.
   (42) Diagnostic durational span. Questions: amount of duration? comparisons with other cancer; what else?
   (43) Experiential data: bad interactional treatment during diagnosis session.
   (44) Wait! Later in the interview we shall see.

Phase 4

1. (1) Directive: Return to interview inspection.
2. (2) Normal–abnormal ambiguity.
   (3) Comparison: EKG, to bring out specificity of M.D. interpretation and diagnostic announcement, versus ambiguity and patient interpretation here.

(4) Difficulty of interpretation because of ambiguity of "numbers" announcement.
(6–10) Fact: What actually told her, and what would she know about "numbers" in general?
(11) Don't worry about the truth for her: The issue is variation.

Phase 5

1. (1) Discussion of "interesting phase" . . . stage of illness.
(2) What then to do? shopping for other diagnoses.
(4) Directive: Code the "all the way" phrase.
2. (5–16) Disease continuum (versus symptom continuum); discussion.
(17) Instructor steers class away from a potential digression.
(18–24) More discussion about disease continuum.
3. (25) Issue of the physician's diagnostic announcement.

Phase 6

1. (1–9) Questions and answers about information; consequences of "freaked out".
(10–12) In vivo code, and conditions.

Phase 7

1. (1) Question: What are these lines about?
(2–7) Discussion about diagnostic career . . . variation . . . some conditions for.

Phase 8

1. (1) An ambiguous announcement.
(2–11) Discussion of "weird"; what it might mean.
(12) Instructor relates it to disease continuum, trying to get discussion off a fruitless path.
(16–22) Diagnostic steps re diagnostic career.

Phase 9

1. (1) Student's suggestion.
(2) Wait! Maybe that will show up later in the interview. But write a reminder memo.

Phase 10

1. (1) Question: What is this paragraph about?
(2–3) Comparison concerning interaction
(4–9) What is "interaction" all about?
(10) Spelling that out via the interview lines; and again, a focusing question.
2. (13) An answer.
(14–16) Diagnostic announcement . . . properties of announcement style; properties of the announcement.
(17) Consequences of properties of announcer's style.

Phase 11

1. (1–5) Information about diagnostic step.

Phase 12

1. (1) What does that line mean? Convert it analytically.
(3) Diagnostic directives and diagnostic career path.
(4–5) Scheduling of the next step of diagnostic career.

Phase 13

1. (1) Comparison case; now analyze it.
(2) Student: analysis re diagnosis and patient career relationship.

Phase 14

1. (1) Question about the announcement.
(2) Answer: variation.
(3) Properties of the announcement.
2. (4) The issue of control by patient . . . and decisions by patient.
(5) Medical funnel; properties; an aside on provisional naming of categories.

Phase 15

1. Summary

Phase 16

1. (1) Issue of another diagnostic sign and announcement.
2. (2–6) Discussion of lump–pimple contrast re the interview data.

Phase 17

1. (1) Let us move along quickly because of today's time constraints.
   (2–3) Data again . . . issue of costs, variations of that subject.

Phase 18

1. (1) Back to the interview.
   (2–8) Staff's focus on clinical problem, not on patient; discontinuities in the diagnostic process.
2. (9–13) Student raises issue of staff noncommunication. Instructor gives experiential data.
   (14) An analytic point.
   (15–22) Discussion of discontinuity, again.