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Co-Topical Small Talk: Troubles-Telling in Traditional Chinese Medical Encounters

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Research has suggested that a rigid dichotomy between small and professional talk is misleading given the porous nature of 'types' of talk. Yet, other research considers this distinction helpful in understanding the functions of talk in situated contexts. This article contributes to this discussion by discussing one type of small talk—co-topical small talk (CST). Drawing from Hudak and Maynard's (2011) understanding of CST as talk that combines instrumental and small talk, we further discuss the bigness of such talk in holistic medical encounters. Specifically, we focus on the ambiguity embedded in participants' turns that allows the navigation of topics between the small/big talk distinctions. We use Conversation Analysis focusing on a routine traditional Chinese medicine doctor–patient encounter. Our data present a case where CST comfortably and appropriately emerges and develops into extensive troubles talk that forms the main activity in caring for older adults. We conclude that the smallness/bigness of talk is determined by the nature of the context and the relevancy of the topic to the encounter.

INTRODUCTION

In medical contexts, professionals and patients sometimes engage in small talk and participate in various interactional tasks such as rapport building (McDonald 2016; Ragan 2000), silence killing (Jin 2018), and temporarily disattending to the tasks underway (Maynard and Hudak 2008). Researchers have described how small talk may intertwine with professional talk in medical encounters (Ragan 2000). Yet, studies have also observed that when small talk moves beyond the agenda of medical concerns and develops into troubles talk sequences, professionals may divert, curtail, or disattend such troubles talk, pre-empting it from becoming 'too big' and disrupting the ongoing medical agenda (Benwell and McCreaddie 2016). However, not all episodes of small talk are treated like this, given the current emphasis on patient-centred or relationship-centred medicine. This is particularly the case when the encounter aims to provide holistic therapy such as traditional Chinese medicine (TCM). Central to TCM pathology and philosophy is the concept of holism, which emphasizes 'the integrity of the human body and the close relationship between human and its social and natural environment' (Lu *et al.* 2004:

1854). Guided by this belief, doctors consider various aspects of the patient's life to determine the diagnosis and treatment. This article presents a case where one 'type' of small talk—'co-topical small talk' (Hudak and Maynard 2011)—functions as 'big' talk, constituting an extensive troubles-telling sequence that reveals critical diagnostic and therapeutic information for TCM treatment. We consider the unique status of co-topical small talk. While being an activity of itself, co-topical small talk (henceforth CST) provides key resources for professional talk due to its capacity to develop into troubles-telling. This research departs from previous research which foregrounds the facilitatory function of small talk. Instead, we argue for the constitutive status of CST in TCM consultations. We propose that in medical encounters like TCM, where diseases are explained not only by evidence, CST can be treated as a resource for understanding the patient and is given an equivalent status as professional talk in interaction. Furthermore, we point to the ambiguity displayed by the participants in medical task/trouble orientation. Such ambiguity carries a special significance in researching small talk in holistic medical encounters due to the dual functions that such talk usually serves and the thrust for understanding the patient as a whole person. Given the current trend to provide TCM or integrate TCM with other health providers, understanding doctor–patient communication in TCM is worth researching. Findings could be illuminative to language researchers, medical practitioners, and patients who visit doctors in different clinical practices. In the latter case, patients might have different expectations of their medical consultations (e.g. to what extent talk that is disengaged from the core medical agenda is appropriate).

LITERATURE

Co-topical small talk

Scholarship on small talk has yielded varying definitions, from the early Malinowskian (1923) formulation of phatic communion to the current context-based understanding of small talk as a continuum (Holmes 2000). This 'continuum' understanding of small talk to include different modes of talk not directly related to the medical agenda is also adopted by the Roter Interaction Analysis System (Roter and Larson 2002)—a widely used quantitative coding scheme.

Some studies, of medical encounters (Penn and Watermeyer 2012; Walsh 2007) and other contexts (de Stefani and Horlacher 2018; Holmes 2000; McCarthy 2000) have criticized the conventional dichotomous notion of the relevance of small talk, given the fuzzy boundaries between what is socially and institutionally constituted (Roberts 2008) and the speakers' changing priorities as the talk develops (Coupland 2000b). This porous nature of talk is particularly salient in medical interviews, which feature hybrid modes of talk (Roberts and Sarangi 1999), and these modes can be closely interwoven with

each other. Ragan (2000) discusses the enmeshed quality of small talk in women's healthcare encounters. She argues that what otherwise might be considered superfluous chitchat, which is unrelated to the core tasks of medical interviews (topicalized small talk or TST in Hudak and Maynard's scheme), can be an appropriate professional talk as well. Similarly, Benwell and McCreaddie (2016) examine the emergence of small talk in a stepwise transition (Jefferson 1984a) from patients' health-related information, demonstrating an interrelatedness between patients' medical problems and their social lives. Such a stepwise progression of topic shift also manifests in other activities in medical encounters (Heritage and Sefi 1992; Maynard and Hudak 2008). It seems that medical interviews are a pool of activities that can seamlessly or naturally evolve into others without disrupting the principal tasks due to the nature of the context. These findings, therefore, support Roberts and Sarangi's (1999) notion of hybrid activity types. The hybrid nature of medical interviews brings to the fore the potential of CST as a prime locus for examination to explore how this hybridity is realized at the micro-level sequential organization of medical interaction. Studies also agree that while small talk, in most cases, aligns with participants' social identities, it may also index people's institutional identities pertinent to its sequential placement (e.g. emerging as an extended response to a medically related inquiry). This latter understanding of small talk allows us to consider CST as a unique type of talk different from phatic communion or TST, thus worthy of close investigation.

A clear definition of CST would help distinguish it from other related constructs of small talk in medical encounters. Hudak and Maynard (2011) first coined the term to refer to talk that combines instrumental and small talk. As the name suggests, CST features a dual relevance to both the instrumental topic and what otherwise might be considered personal/social/relational. In that sense, CST allows the emergence and interaction of some 'boundary-crossing activities' (see Marra *et al.* 2017: 228). This feature sets CST depart from other types of small talk like phatic communion (Laver 1975) or TST (Hudak and Maynard 2011). Unlike talk independent of participants' institutional identities and more oriented to their personal biographies, CST is 'instrumentally related to the ongoing medical talk while performing other actions' (Hudak and Maynard 2011: 647). While the concept of CST is briefly defined in Hudak and Maynard's study, it is not subjected to comprehensive analysis.

To expand our understanding of CST, this article presents a detailed analysis of the dynamics of CST in a routine holistic medical encounter. In this encounter, what initially started as a personal-state inquiry (Jefferson 1980; Sacks 1975) is fully developed into extended troubles-telling where CST comfortably emerges, and which, in turn, constitutes a critical component of medical consultation. We argue that due to the affordances of CST in medical interaction to straddle the interpersonal dimension of troubles-telling and the

institutional goal of providing medical service, and to subsume these into a stream of potentially relevant talk, CST requires further research to explore its use and application in a variety of contexts.

Troubles-telling in medical encounters

In a series of seminal studies, Jefferson and her colleagues bring into focus a range of interactional sequences in everyday conversation, where people introduce and talk about their troubles. According to Jefferson (1980: 153), the central feature of troubles talk is the 'tension between attending to the "trouble" and attending to the "business as usual"'. Crucially, Jefferson and Lee (1981) note that there is a strong convergence (see also ten Have 2016) between troubles talk and the service encounter; and that in the service encounter, the trouble alternates with the problem. In other words, what otherwise would be considered off-task (Hudak and Maynard 2011) can be relevant to the accomplishment of the tasks in situated encounters. This is particularly relevant to our analysis as we focus on topics that bridge the conventional and debatable boundaries of small/professional talk. In this article, we consider that insofar as troubles talk usually involves self-disclosure sequences (Grainger *et al.* 1990) of some difficult and embarrassing episodes (Benwell and Rhys 2018), 'private and personal' issues (Wowk 1989) which are indicative of patients' personal experiences and lifeworld (Mishler 1984), such talk should be treated as an activity of which CST is an integral part, i.e. as a constitutive feature of the activity. As ten Have (2016: 121–22) states, 'troubles-telling consists in a telling of some trouble, a reception of that telling, in such a way that it can be considered as a moment of "phatic communion", as a building of "emotional reciprocity" concerning the troublesome experience involved.'

Furthermore, Jefferson and Lee (1981) remind us of the different interactional expectations of service encounters and troubles-telling, with advice-giving an appropriate activity in the former and emotional reciprocity in the latter. Specifically, Jefferson and Lee explain the rejection of advice at an earlier stage (or 'sequential prematurity', Jefferson 1988) as a refusal to shift interactional alignment to that of a service encounter. Their study demonstrates the importance of the context (both the local sequential environment and the broader institutional context) in determining the social activity. This finding is particularly insightful and relevant to the present study, which argues that holistic medicine encounters like TCM allow CST to emerge appropriately and comfortably into extensive troubles-telling, rather than being diverted or curtailed as in other medical encounters (Beach and Mandelbaum 2005; Benwell and McCreaddie 2016).

Troubles-telling has been examined in other medical settings, functioning as important resources for the revelation of information central to medical tasks (Benwell and Rhys 2018; Ruusuvuori 2007; ten Have 2016). As detailed

analysis revealed: 'the locally achieved contrast between these two types of response [emotional reciprocity and information checking] ... is about medical relevance rather than the choice between information recording versus empathy' (Benwell and Rhys 2018: 224). Studies of nurse–counsellor interactions with mastectomy patients found that 'emotion talk' is a constituent feature of the therapeutic consultation—it is the business of the session and problematizes a priori separation between small talk and medical talk (Wowk 1989).

METHODS AND DATA

This investigation is a single case analysis (Schegloff 1987) of a regular medical visit between a doctor and a repeat patient during a routine medical visit. The doctor specializes in TCM internal medicine. The patient is an elderly female adult. Her child is studying overseas. She has seen this doctor on several occasions prior to this visit. Our data show how CST can comfortably and appropriately emerge and fully engage the participants throughout the interview. It also shows how such a full engagement reveals fundamental information for the diagnosis, treatment, and advice-giving—core medical tasks. We draw on Conversation Analysis (Sacks *et al.* 1974) to analyse the data. Orthodox conversation analysis identifies norms or orderliness of social practices generated from an aggregate of observations, as collections of instances. In this article, we capitalize on the momentum to use Conversation Analysis on a single case, to describe these norms and the orderliness as per each interaction for its participants. As Schegloff (1987: 102) states, 'social action done through talk is organized and orderly not, or not only, as a matter of rule or as a statistical regularity, but on a case by case, action by action, basis.' Single case analysis allows us to maintain contact with the mutable, unfolding contexts of the interaction.

Transcriptions were produced using Jeffersonian conventions (Jefferson 2004). Three-line transcripts are provided where the first line presents the Chinese pinyin original; the second line offers a word-by-word gloss of the Chinese, and the third line provides an idiomatic translation. The data we present here is part of a larger study that examines doctor–patient communication in TCM encounters. Research ethics protocols were followed throughout this project. Permission to record was obtained from both the hospital and the first author's home institution. Informed consent was obtained from all the participants prior to their participation. Participants were approached at the waiting area outside the consultation room. To protect identities, data were audio-recorded and all participants were kept anonymous. In the transcript data presented below, D stands for the doctor, and P stands for the patient. Both participants are female.

TCM encounters: features

Before moving onto the analysis, a brief introduction of TCM is necessary. TCM is a holistic approach with an emphasis on achieving a balance between the human body and the universe. It believes that the human body is an integral whole closely related to the outside environment. Unlike Western medicine, which is highly evidence-based, a TCM diagnosis considers an amalgam of various factors such as emotions, weather, and lifestyle. When TCM doctors see patients, they tend to consider them holistically (Mead and Bower 2000), to understand their lives before making a diagnosis. Therefore, TCM is also understood as personalized medical treatment (Wang and Zhang 2017). This is not to say that Western medicine denies the importance of patients' lifestyles and other person-related (in contrast to the disease-related) factors. Instead, the two approaches place a different weight on the value of these environmental and person-related factors on health. As Chen and Xu (2003) state, Western medicine focuses more on disease and pathology than on the person, on parts rather than the whole, while TCM places more emphasis on the diseased patient rather than the disease. These features of clinical culture affect, if not determine, doctor–patient interactions and influence the topics discussed.

To see a TCM doctor, patients need to register either in person or online to take a number. Patients will be called by a nurse or a medical assistant to get prepared before their turn. Alternatively, they can watch the TV screens on the wall. The numbers are flashed on the screen as well as announced via voice.

ANALYSIS

We present an entire real-life medical interview below. For heuristic rather than analytic purposes, the conversation is divided into different segments: initiating CST, CST, transition between hybrid modes of talk, proffering solutions to troubles, professional talk, TST: sarcastic humour, CST: co-parenting, and closing the encounter. We want to point out that while we differentiate CST, TST, and professional talk for better illustration of the unique status of CST in medical interaction, we consider the distinction as less than clear-cut. It is analytically problematic to assert the exact point at which one mode transits to another. A distinctive feature of CST lies in its compatibility with both professional talk and talk that is distant from the core medical agenda.

The patient was in her late fifties and had seen the doctor several times prior to the present visit. The patient was suffering from serious insomnia. The patient sat down on the chair and passed the doctor her written medical history while the previous patient was about to leave.

Extract 1: Initiating CST

((four lines omitted))

5 D ni zenmeyang le?
You how PRT
How are you?

6 P wo xianzai(.)jiu shi nage (.)shuimian ou[(.)=
I now just be that sleep PRT
I am just that (.) my sleep *ou*

7 D [en
[Hmm

8 P =MEITIAN zuomeng tiantian zuomeng(.)[wo
everyday dream everyday dream
=I dream EVERYDAY dream everyday(.)[I

9 D [>nimen jiali=
your family

10 =de shier you mei you jiejue diao?<
PRT thing have not have solve have
=[>Is your family problem solved?<

The interview starts with a conventional 'how-are-you' inquiry (Heritage and Robinson 2006). In Line 6, the patient's articulation of the final particle *ou* at a transition relevant place indexes extraordinariness (Wu 2004), projecting the information following as newsworthy and problematic. As the patient presents her problem (Line 8), the doctor asks about her family issues (Lines 9–10), which shows the doctor's orientation to the patient's family issue as a potential cause for her current health condition. In so understanding, the doctor's question on the patient's family issue instantiates the initiation of CST. Unlike small talk which disattends the on-going medical task (Maynard and Hudak 2008), CST in our data shows a parallel attentiveness to both the troubles and the on-going medical task (see discussions below).

Extract 2: CST

11 P °°mei ne= na you name kuai°°
No PRT how have that fast
°°Not yet- how could it be so soon?°°

12 D °shangci shi shuo ni jiali shenme shier?=
last time be say you family what thing
13 = wo [dou wang le°
I almost forget PRT
°What was the problem? You mentioned it last time, I forgot it.°

14 P [wo xiaohai
my child
[My child

15 D a?
Ah?

16 P wo xiaohai:
my child
My chi:ld

17 D xiaohai zenme le?
Child what PRT
What is wrong with your child?

18 P wo xiaohai shilian: he [he
my child dump heh heh
My child was du:mped, heh he[h.

19 D [ou: ((the doctor takes the patient's pulse)
[Ou:

20 P heh heh ai:you(.)>fanzheng wo jintian hai zai quan ta =
heh heh PRT anyway I today still be persuade him
21 = ta gen wo shuo meishi de mama
he to me say nothing PRT mom
Heh heh *ai:you(.)* >anyway I am still persuading him today=
= He said it's nothing, mom.<

22 D °hao de°
fine PRT
°She[1] is fine.°

23 P ni shuo ta bu dongshi me ye ting dongshi de
you say he not sensible PRT actually very sensible PRT
you may say he is not sensible, but actually he is very sensible

24 D =ga ta meishi le NI you shier le
so she nothing PRT you have thing PRT
=So she is fine, and you are not.

The topic of the patient's family is collaboratively developed. After the patient's response which is hearable as having a negative import, projecting a trouble to report (also note the paralinguistic features of articulation in a soft voice and the rhetorical question) (Line 11), the doctor pursues the topic of the patient's trouble (Line 13). At first, the patient provides a short minimum amount of information 'my child' (Line 14). Prompted by the doctor's repair initiation (Line 15), the patient again provides the answer in the form of a noun phrase (Line 16). The doctor invites the patient to elaborate more on the issue (Line 17), and the talk concerning her child's recent relationship follows (Lines 18, 20–21, 23). Here, one can say that the doctor's pursuit of the patient's trouble is a stepwise transition from professional talk to CST that gradually disengages from the prior talk on the patient's poor sleep (Line 8, Extract 1). However, the doctor's formulation at Line 24 returns to professional talk by shifting the focus to the patient not being 'fine'.

The doctor's response 'ou' (Line 19) to the patient's pursuit of further telling deserves further analytic scrutiny. The neutral acknowledgment 'ou' registers information receipt (Wu 2004) and displays the speaker's treatment of the information offered as sufficient; it can also indicate attentiveness, functioning as a backchannel, or a 'continuer' (Jefferson 1988: 423), displaying an invitation to talk further. It is this neutrality that embraces an ambiguous orientation to the speaker's turn. The ambiguity is also manifest at another level: while occasioning further talk, the acknowledgment also displays a neutral orientation towards the prior talk as trouble and 'constitutes [...] a pressure towards business as usual' (Jefferson 1988: 424). This interpretation is further supported by the nonverbal activity of taking the patient's pulse (Line 19), a required institutional activity in medical encounters.

The doctor's affiliative response in Line 22 is also ambiguous. While the action can be seen as aligning to the information conveyed in the patient's prior talk, it being a short and positive summary ('she's fine') might suggest a closure to the ongoing sequence (Ruusuvuori 2007). Here, the negative construction in the patient's utterance ('it's nothing') is replaced with a more positive expression ('she's fine') in the doctor's reformulation, displaying her non-alignment with the patient's trouble orientation. This is further evidenced in Line 24, where the doctor re-announces her non-trouble orientation to the reported issue in the patient's prior turn while suggesting a problem ('[but] you are not'). The utterance is articulated in a way that connects patient health to the trouble, hearable as both professional and affiliative.

Extract 3: Transition between hybrid modes of talk

```
25 P °meiyou(.)qishi    >ta zhende<(.)wo juede
       no      actually   he really   I  think
26    meiyou name kuai =na  you name kuai°
       no     that fast  how have that fast
      °No(.)in fact >he is really<(.)I don't think he is fine now.
      How could it be so fast?°

27   yige duo xingqi guole dui   bu  dui? Shuo  shizai   de ou
      one more week  gone  right not right say actually PRT PRT
      It's only more than a week, you know? To tell the truth oh

28 D ta   ZHIYAO      bu YAOSIYAOHUO  me=
      then (s)he as long as not live, kill and die PRT
29    = ni  jiu   sui   ta   qu lou
        you just leave her alone PRT
      AS LONG AS she doesn't live and die for love just leave her alone.

30 P ↑ta xianzai JIU zheyang a=
      (s)he now   just this  PRT
31    = yinwei women zheli bu shi you  shicha          a
        because we   here  not be have time difference PRT
      He IS ((like that))now, because of the time difference
      between us
```

32 D em
Um

33 P ta ta xianzai jiu gen wo shuo mama wo mei <wo shui bu zhao =
he he now just to me say mom i don't <i sleep not PRT
34 =ni shuo wo shui bu shui de zhao(.)dui bu dui a?=
you said i sleep not sleep PRT PRT right not right PRT
35 =wo dabaitian de ta yinggai shi wanshang ya=
i daytime PRT he should be evening PRT
36 =mama wo shui bu zhao(.) ni hao bu hao=
mom i sleep not PRT you good not good
37 =wen wo hao bu hao(.)wo shuo wo hao de(.)=
ask me good not good i say i good PRT
38 =wo shuo ni hao wo jiu hao le >ZENME NONG< a? =
i say you good i then good PRT what do PRT
39 = wo ye mei banfa wo jiu quan ta ta shuo=
i too no method i just persuade him he say
40 =ni buyong quan wo de ni buyao name jiaolv de=
you don't persuade me PRT you don't so anxious PRT
41 = wo [bu
i no
Now, he says mom I don't < I can't fall asleep. Then how could I fall asleep, right? It's the daytime here, so it should be very late in her time. Mom, I can't fall asleep. How are you? I told him that I'm good (.) I said I am good as long as you are good. This, WHAT TO DO with it? I have no idea. I can do nothing but persuade him. And he said you don't need to persuade me. You don't need to be so anxious. I am [no

42 D [shi a wo- ni zhe MAI limian zhe=
yes PRT i you this pulse inside this
43 = jiaolv MAN MAN de
anxiety full full PRT
[Yes, I- your pulse is hearable as FULL of anxiety.

44 P wo shuo he wo shuo ni bu jiaolv wo jiu bu jiaolv le=
i say heh i say you no anxious i then no anxious PRT
45 =wo shuo he he wo dou shi kuai jiaolv si le=
i say heh heh i all be soon anxious die PRT

46 =wo he he
I heh heh
I said heh I said as long as you are not anxious, I won't feel anxious. I said heh heh I am so anxious, almost dying. I heh heh.

47 (0.4)

48 P shi zai guowai fasheng °zhe Zhong shi°=
be in abroad happen this kind thing
49 =ranhou wo xian:zai ou wo xianzai bu neng ji=
then i no:w PRT i now not able anxious
50 =ta zhiyao yi shuo shenme shiqing ou=
he as long as once say what thing PRT
51 =wo jiu naodai hui weng: yixia
i will head will buzz once
It ((the ending of a relationship)) happened when he was abroad. Now, I can't be anxious. Once he told me something, my head would bu:zz.

In Extract 3, we see seamless transitions between hybrid modes of talk (Roberts and Sarangi 1999). From Line 25 onwards, the talk shifts from a

reporting mode to a more expressive one (Jefferson 1985). The patient exhibits her feelings (worry, concern, anxiety) about her child as the conversation unfolds. In Lines 25–27, we can see an escalated mode of troubles-telling, despite the fact that the doctor is not aligning herself as a troubles-recipient. The escalated troubles-telling displays the patient's resistance to the doctor's orientation towards professional talk, changing the topic back to troubles talk. Here, talk on the child's difficulty in recovery from her broken relationship is less relevant to her status as a patient or the institutional task of the encounter (compared with the talk on poor sleep and later on headache). Yet, such talk also differs from 'phatic communion' and Hudak and Maynard's notion of TST in that it is not completely outside the domain of the medical interview (cf. Beach and Mandelbaum 2005), given its relevance to the patient's health. Put differently, the sequences of expressive mode of talk on the child's difficulty in recovering are co-topical in the situated interaction.

The doctor does not adopt the troubles-recipient stance: in her advice (Lines 28–29), the trouble is downplayed, designed in a conditional clause ('as long as'). In so understanding, the doctor possibly indicates an orientation towards a sequence closure (Ruusuvuori 2007). The contrast is visible between the doctor who treats the trouble as reducible and the patient who disagrees with the doctor's assessment of the trouble as the patient describes her child's state as 'She IS (like that) now' (Line 31). The patient hearably pursues ratification of her troubles: The intonated temporal reference 'IS' (Line 30) indexes the seriousness of the trouble and justifies the patient's anxiety. While not actively pursuing an elaboration, the doctor's response in Line 32 ('em') allows the patient to go ahead with her lengthy account of the trouble (Lines 33–41). In that account, she repeatedly proposes an understanding of her condition as intimately related to the child: 'I said I'm good as long as you're good' (Line 39) and indicates helplessness 'What to do with it, I have no idea' (Line 40). In building a tie between her child and her health, the patient swiftly navigates between medical talk and troubles talk. Given the nature of her trouble, such talk involves information that is mildly distant from the medical agenda (e.g., reporting the conversation between the mother and the child, the concern that the child shall not recover soon). In this context, CST comfortably emerges and develops into troubles-telling. While formulated in terms of medical diagnosis ('full of anxiety in the pulse'), the doctor's response (Line 42-43) expresses empathy and displays 'trouble receptiveness' whereby she allows the patient to continue her troubles-telling (Lines 44–46). Note that there is an inter-turn pause in Line 47, where the doctor could have taken a turn. However, she lets the patient continue with her troubles-telling (Lines 48–51) where her physical symptoms (e.g., headache) and her personal stories are presented in an intertwined form, and the doctor finally takes up her turn (Line 52), which continues in Extract 4.

Extract 4: Proffering solutions to troubles

```
52 D ni shangban de ma? =ni xianzai shangban ma?
     you work    PRT PRT you now   work     PRT
     Are you still working? =Are you working now?

53 P bu shangban a
     no  work   PRT
     Not working.

54 D bu shangban me pao yitang bujiu xing le ma?
     no work    PRT run once   will  okay PRT PRT
     You are not working then you just go t'ere and that's it.

55 P dao nali a?
     to where PRT
     Where?

56 D qu kan ta qu
     to see her to
     To visit her.

57 P ↑kan ta me(.) wo rang ta gei wo kai  xiyi=
      see her PRT  i  let him to  me give western medicine
58   =zhengming   ta bu  ken   ni zhidao ba?
      testimonial he not agree you know  PRT
     ↑To visit her(.)I asked my western medicine doctor to
     provide medical approval but he did not agree, you know?

59 D lvyou ne? ((referring to the visa type))
     travel PRT
     How about travel?

60 P lvyou  jiu  hen   nan       a
     travel will very difficult PRT
     Then it's difficult.

61 P ranhou ta shuo ni buyao lai(.)ni   lai le wo geng=
     then   he say you don't come  you come PRT i more
62   =bu  hao(.) wo you haipa(.) ai: wo xianzai he he=
      not good   i again afraid  PRT i  now    heh heh
63   =xianzai shi ernv he  he(.) ta shuo shenme aiyou=
      now     be child heh heh   he say  what   PRT
64   =wo xiang wo buyao ciji     ta
      i  think i  don't irritate him
      Then he said don't come, I would be worse if you come.
      Then I am afraid(.) ai ((sigh)). Now, I heh heh, the child
      now, heh heh, whatever he said, aiyou, I thought I'd
      better not irritate him.

65 D toutong  ne? toutong  hai   tong bu tong?
     headache PRT headache still pain not pain
     How about headaches? Do you still get headache?
```

The doctor's question on the patient's working status (Line 52) might be seen as irrelevant to her institutional role as a doctor, yet it turns out to be

relevant as it was meant as a preliminary to a proposed solution to the patient. Here, talk on working status is more co-topical than professional. Yet, the doctor's formulation of a possible solution is not taken up by the patient (Lines 57–58). In her second declination of the doctor's advice (Line 60 and onwards), the patient takes the opportunity to elaborate on her trouble and presents the child's reaction as a reason for rejecting the advice. Jefferson and Lee (1981) note that rejection of advice often has little to do with the quality, relevance, and intention of the advice-recipient to use that advice. They observe that it is instead an interactional matter. We see the patient shifts the focus to her child's condition (Lines 60–64) rather than engaging with the advice. This action is similar to what Jefferson and Lee observe as an attempt to preserve the sense of the current talk as troubles-telling, resisting the shift to the orientation of advice-seeker and advice-giver. Note the two instances of laughter in the patient's turns (Lines 62, 63), are hearable as wry laughs rather than invitations to conjoint laughter (Jefferson 1984b), thus maintaining the orientation to troubles talk.

The patient's trouble orientation is not reciprocated by the doctor (Line 65). By asking a question about the patient's headache, the doctor can be seen as working towards closing the troubles-telling sequence (Ruusuvuori 2007). The organization of two questions in a single turn (Line 65) is hearable as information-checking, featuring the interaction as a routine checklist medical encounter (Benwell and Rhys 2018). This 'checklist' feature is preserved in multiple forthcoming turns in Extract 5.

Extract 5: Professional talk

```
66 P toutong  me you  yiDIANDIAN tong hai   you yidiandian tong
     headache PRT have a little  pain still have a little  pain
     Headache, a LITTLE still feel painful a little painful.
67 D hao   yidian    le?
     better a little PRT
     A little bit better?
68 P hao    yidian   le(.) jiu shi zuomeng(.)zuomeng ou=
     better a little PRT   just be dream     dream  PRT
69  =zui  lihai(.)ranhou jiu shi YIDIANDIAN dou=
     most serious then   just be a little   at all
70  =buneng jinzhang yi jinzhang jiu zhege xuegua[n
     cannot nervous once nervous just this artery
    A little bit better. Just dream, dream a lot. Then, I just
    I just can't be nervous, not even a LITTLE. Once I am nervous,
    my arter[y
71 D                                              [shetou wo kan
                                                   tongue i  see
                                                  [Show me your tongue.
72 (0.3)((the doctor examines the patient's tongue))
```

73 D shetou bi shangci hao qilai le
tongue than last time better PRT PRT
Your tongue looks better than last time.

74 P hao qilai le ou?
better PRT PRT PRT
Better ou?

75 D en
um

76 P wo weikou ye bu hao bu xiang chifan=
my appetite always not good not want eat
77 =bushi hen ai chifan(.) >chi bu chi dou wusuowei de< =
not very like eat eat not eat all mind not PRT
78 =wo faxian shi
i find be
My appetite is poor as well. I have no appetite. I don't want to eat(.) I find that >i don't care if I eat or not<.

79 D ↑na ni you xinshi me=
then you have something on your mind
80 =ni dangran lou
you natural PRT
↑It's natural as you have something on your mind.

81 P shi a
yes PRT
Yes.

82 D [ni zhege zhege zhege
you this this this
[You this this this

83 P [shi a: zhuyao shi zhege] baobei ni shuo shi bushi la?=
yes PRT main be this lovely baby you say yes not PRT
84 =zui yaojin de yige baobei(.) wo liao bu zhe shiba?
most important PRT one dear baby i touch not PRT right
[Ye:s it's mainly because of this] my dear baby, do you agree? He is my dear baby, my most important treasure(.) and I am not with him.

85 D zuiba ku bu ku?
mouth bitter not bitter
Do you have a bitter taste in your mouth?

86 ((the patient nods her head))

87 (1.0) ((the doctor writes the prescription))

((lines 88-101 omitted, discussion on medications))

We see in Extract 5 that the two participants engage in core medical exchanges (focused, highly informative, and strictly relevant). These include patient problem presentation (Lines 66, 68–70, 76–78), physical examination (Lines 71–72), and medical evaluation (Lines 73, 79–80). However, the doctor's secondary evaluation (Lines 79–81), marked by an effort to connect the patient's poor appetite to her trouble, provides an opportunity for the patient to resume the troubles talk (Lines 83–84). The doctor does not align herself to the troubles talk this time (Line 85), leaving the trouble in the patient's prior turn disattended. Instead, the doctor maintains her orientation to professional talk by asking if the patient experiences bitterness in her mouth. After the patient's nodding, the doctor writes a prescription (Line 87). Throughout the next couple of turns, the doctor and the patient maintain mutual alignment by displaying their orientation to the medical agenda and discussing

medications (Lines 88–101). Extract 6 begins with the patient's formulation of a new medical problem.

Extract 6: TST: Sarcastic humour

```
102 P erduo me wengweng de(.)erqie hen  hui     tuofa
      ear   PRT woo     PRT  and   very serious hair loss
    My ears are whistling (.) and my hair loss is serious.
103 D wo KANDAO le(.)ge you shenme banfa   tai LAOXIN   a
      i  see   PRT   that have what method too concern PRT
    I have NOTED this. It can't be solved as you have too many CONCERNS.
104 P ai:you ranhou ou wo zhebian jiu zheli de nage shui=
      PRT    then   PRT i  here   just here PRT that who
105  =jiu shenjing   neike    nage yisheng rang wo=
      just neurology division that doctor  ask  me
106  =buyao ranfa(.) wo shi  bu  xiang ran ou=
       don't dye      i  be  don't want dye PRT
107  =danshi wo juede guobuqu le zhege toufa=
       but   i  think cannot  PRT this hair
108  =chuqu dou 80 sui le ou   he  he  you meiyou? he  he
      out   all 80 age PRT PRT heh heh yes not   heh heh
      Ai:you, then I, the ((doctor)) here, the one
      from the division of neurology advised me not to dye my hair.
      I didn't want to but I think I could not bear it. My
      hair makes me look like I'm 80 year old, don't you think? Heh heh.
109 (1.4) ((The doctor looks down at her notes))
```

The patient presents a new symptom of her physical condition (Line 102). The doctor's affiliative and empathetic response (Line 103) is once again tapped into by the patient as an opportunity to pursue her troubles-telling further (Line 104-108). Here, we note that the conversation gradually evolves into what Hudak and Maynard (2011) call TST. According to Hudak and Maynard, TST refers to talk that is 'referentially independent from the institutional identities as patients or surgeons' (2011: 638). Here, hair talk does not invoke the participants' institutional identities at all.

The laughter embedded in the patient's exaggerated statement 'looks like I'm 80-year old' is hearable as sarcastic humour that contradicts the true state of affairs (McDonald 2000). The patient's seeking for an agreement 'don't you think?' is hearable as an orientation towards emotional reciprocation. While an appropriate response to such a question may have been disagreement (e.g. 'no, you look pretty good'), the doctor displays disengagement from furthering the current talk on hair by not responding (Line 109). At this point, the doctor looks down at her notes as if to close the topic. A sizable pause develops here (Line 109). In other words, the TST in the patient's turn is not taken up by the doctor. After the 1.4 second pause, the patient picks up her turn again (Line 110), which continues in Extract 7.

Extract 7: CST: co-parenting

```
110 P wo jiushi ta bulai- wo erzi bu    gei wo fa
      i   just  he doesn't  my son doesn't give me send
111   =weixin woziji tiaojie de ting  hao de=
       wechat myself adjust  PRT very good
112   =ta yi   gei  wo fa   weixin wo j[iu
       he once give me send wechat i  just
     I am, if he doesn't- if my son doesn't text me I am fine.
     When he texts me, I am j[ust

113 D                                  [↑waimian nage shi ERZI a
                                        abroad  that be   son PRT
                                  [↑The child who is abroad is your SON?

114 P en
     em

115 D wo haiyiwei shi nver(.) erzi me YUEJIA le lou- =
      i  think    be  girl    son  PRT more  PRT PRT
116   =zhenshi de(.)erzi me ni-
       really  PRT  son  PRT you
      I've thought that it was a girl (.) he's a boy, then you
      should be MORE-, you're really, he's a boy, you-

117 P xianzai erzi gen nver chabuduo le
      now     boy  and girl similar  PRT
      No difference between boys and girls now.

118 D ↑nashi  ni  guan  de  TAI  lao   le
        That's you watch PRT too tight PRT
      ↑That's because you watch him too closely.

119 P ↓na   daoshi shishi
        that is     truth
      ↓That's true.

120 D ↑guan  name  lao ganshenme? erzi me yuejia fangshou de lou
        watch that tight why       boy PRT more   let go  PRT PRT
      ↑Why so bossy? For a boy, you should give him MORE freedom.

121 P wo  pa    t[a
      i  afraid he
      I am afraid if h[e

122 D             [wo haiyizhi yiwei shi ni   nver ne
                   i  always   think be  your girl PRT
                        [I've always thought that you were talking
       about your daughter.

123 P (h)e wo ba ta dang nver yiyangde(.)dang [baobei
       heh i  to him as  girl  same      as   treasure
      (h)eh I treat as my beloved girl.

124 D                                        [>na  bu  xing de<
                                              that not work PRT
                                                      [That can't work.
```

125 P =yiyang de
same PRT
(H)eh heh I treat him as if he were my daughter, [my treasure.

126 D ↑na: bu xing de(.) erzi zenme hao dang nver yang ne=
that no work PRT boy how can as girl raise PRT
127 =nver dang erzi yang shi meiyou guanxi de
girl as boy raise be no matter PRT
↑Tha:t can't work. How can you raise a boy like a girl.
It's fine you raise a girl like a boy.

128 P nao shaowei yilai mama zenmeban (h)e he(.)=
look a little once mom how heh heh
129 =qianmian ta dou bu gen wo shuo(.)wo pinming ou=
at first he all no to me say i try hard PRT
130 =wo xianzai jiushi women yao gen ta zuo pengyou=
i now just we need to him make friends
131 =ta cai gen women shuo xinlihua(.)=
he will to us say something in his mind
132 =wo jiu pa ta bu gen wo shuohua(.)=
i just afraid he no to me say
133 =ni zhidao ba (h)e ta fanzheng (h)e
you know PRT heh he anyway heh
Look, when something happens, he's like mom,
what shall I do. (H)eh heh. At first, he didn't tell me
what happened. I tried very hard (.) Now, I just, we
need to act as if we're his friends so that he is willing to share
with us what's on his mind. I am just afraid that he doesn't
talk with us. You know? (H)eh, he's, anyway, (h)eh.

134 D zhege: ni zhege zhuangtai shi zuo bu liao pengyou de=
this you this status be make no PRT friend PRT
135 =ta yongyuan shi yilai ni de
he forever be depend you PRT
Thi:s, you cannot be his friend if you act this way,
he is always dependent on you.

136 P DUI ta hen zhuai de(.)zaijiali(.)=
yes he very arrogant PRT at home
137 =dou bu li wo de=
at all not attend me PRT
138 =fansile fansile jiu zheme dui wo de
annoying annoying just this to me PRT
139 =xianzai zai waimian ou wo wen ta ni zenmeyang ou ((inaudible))
now at abroad PRT i ask him you how PRT
YES. he is very arrogant at home(.) he doesn't pay me
any attention. You're so annoying, so annoying. He's like that. Now,
he is abroad, I ask him how are you ((inaudible)).

140 (0.8)((the assistant calls for the next patient to prepare))

The patient resumes her troubles talk in a way that connects (using the if-clause) her health with the trouble (Lines 110–112). As the patient's statement contains an orientation to both her trouble and medical condition, it forms CST. In contrast to the curtailing moves, we have seen at the end of Extract 5 and Extract 6 (Lines 85 and 109, respectively), the doctor responds by topicalizing the trouble via asking a clarification question: '↑The child who is abroad is your son?.' Until now the doctor had proceeded as though the

patient was talking about her son instead of her daughter. This misunderstanding can be explained by the phonological homogeneity in three different personal pronouns in Chinese ('it', 'he', and 'she'). Therefore, unless explicitly told ('my son', Line 112), one could hardly tell the gender. Here, the pitch shift and markedly increased volume in the doctor's turn displays surprise (Line 113), which is problem-indicative. Most importantly, the doctor's turn interrupts the patient's talk at a point when she is most likely to provide health-related information (like symptoms). Note the position of the onset of the doctor's turn in Line 113.

In response to the patient's brief affirmation (Line 114), the doctor's turn hearably indicates a problem orientation towards the patient's parenting (note the increased volume and intonation of *YUEJIA*) ('MORE', Lines 115–116). The patient provides a rebuttal by advancing her views on parenting (Line 117), which suggests a change in social norms regarding parenting, justifies her behaviours, and displays a non-problematic orientation towards her parenting. This sequence leads to an understanding that the two participants have shifted their alignment vis-à-vis each other to 'mothers' rather than 'doctor and patient'. The doctor provides an additional view on the patient's parenting style (Line 118), which is agreed upon by the patient this time (Line 119). The doctor then continues with her advice on parenting (Lines 120, 122), which encourages expansion on parenting talk. The patient elaborates on how she treats her son (Lines 123 and 125) and her progress in getting along with him (Lines 128–133). Here, talk on the patient's progress with her son constitutes a sort of narrative expansion (Benwell and Rhys 2018; Stivers and Heritage 2001) that departs from the medical agenda.

The doctor proceeds with her advice on/criticism of the patient's parenting style (Lines 134–135). The patient responds with an agreement indicated by the intonated *DUI* 'YES' (Line 136) and provides further personal disclosure (Lines 136–139). The assistant's call for the next patient (Line 140) is a reminder to both the doctor and the patient of the time limit, providing explicit grounds for a possible closing (West 2006) of the encounter.

Extract 7 presents a clear illustration of how CST develops into troubles-telling, which turns out to serve the main goal of the institutional encounter in this specific setting. Since the nature of the patient's trouble is closely intertwined with the patient's health, we argue that the parenting talk here is related to the medical agenda, and as such is describable as CST. On the other hand, unlike cases reported by Benwell and McCreaddie (2016), the talk develops to the extent that allows both parties to advance their views on parenting (e.g., 'no difference between boys and girls now'), thus shifting the focus away from the professional talk. However, while the participants' identities as mothers are foregrounded as they are engaged in parenting talk, their enactment of personal identities as mothers is also affected by their institutional identities. This means that in this sequence the expression of personal identities is reflexively related to their institutional identities: these personal/professional identities mutually elaborate each other. The doctor articulates

her disagreements in a repeatedly strong and assertive manner by using high pitch at the onset (Lines 120, 126–127), thus enacting her identity as an advice-giver. By contrast, the patient responds more softly with low pitch (Line 119) at the onset and a laugh-initiation (Lines 123, 128–133), hence being a trouble-teller. The difference in their behaviours displays some conversational asymmetry, which could be explained by their institutional identities.

Extract 8 presents the closing section of the interview.

Extract 8: Closing the encounter

```
141 D haihao ((the doctor provides an evaluation of the current patient))
      not bad
      Not bad.
142 (0.2)
143 P nage hongzao  ye   yao  chi  de ou =
      that  dates  also need eat PRT PRT
144   =hongzao ye  hao  de   ou(.) wo pa  sh[i
       dates  also good PRT PRT    i worry be
     That, I still need to eat the dates right?
     Dates are good right? I am worried that'[s
145 D                                        [buyao chi=
                                              don't eat
146   =ni buyao chi
       you don't eat
                                             [Don't eat that,
       Don't eat that.
147 P yinwei ta[i
      because too
      Because it's to[o
148 D          [ni buyao chi (.) niziji   jian    de  ou?
                you don't eat  yourself concoct PRT PRT
                     [Don't eat that(.)you concoct the herbs
      on your own, right?
149 P dui wo dou ziji   jian    de
      yes i  all myself concoct PRT
      Yes, I've always made it myself.
150 D hao
      okay
151 P xiexie    ou
      thank you PRT
      Thank you.
((the patient left. End of tape.))
```

In line with the assistant's call for the next patient, the doctor announces a departure from the prior talk by providing an overall evaluation of the patients' health (Line 141). The patient aligns with the doctor by making a closure-implicative inquiry, i.e. seeking dietary advice (Lines 143–144, 147)—

a commonly observed activity in closing sections in TCM (Jin and Kim, unpublished data). After responding to the patient's inquiry, the doctor's confirmation check question regarding the patient's herbal concoction preferences (Line 148)—another activity found to occur regularly in the closing section of TCM clinic encounter—brings the sequence ready to be closed. In brief, both the doctor and the patient understand the assistant's turn (Line 140) as a closing implicative, and they make moves to a pre-closing (Schegloff and Sacks 1973; West 2006). The sequence is closed with the doctor's pre-closing utterance *hao* (Line 150) and the patient's expression of gratitude (Line 151), thus confirming the visit as a service encounter.

DISCUSSION AND CONCLUSIONS

This article has presented an analysis of a routine TCM consultation. We report a case where CST gets expanded to full-fledged troubles talk, which serves the aim of the encounter rather than 'com[ing] into conflict with the aims of the interaction underway' (Benwell and McCreaddie 2016: 258). Previous literature has reported that patients' reports of lifeworld experiences that may be relevant to the patients' health concerns are held in abeyance (Benwell and McCreaddie 2016) or not taken up by healthcare providers at all (Beach and Mandelbaum 2005). In our data, we see a convergence (Jefferson and Lee 1981; ten Have 2016) between engaging in CST and professional talk, in troubles-telling and task completion. Given the discrepancy between the professional role and a troubles-recipient, we also see instances when the doctor momentarily shows her resistance/non-alignment with troubles-recipiency and tendency to shift the interaction back to the medical agenda.

In the article, we focus on how CST was invited and co-constructed by the doctor and the patient to be an integral part of an extensive troubles-telling sequence that reveals critical information for the patient's health. We identify instances of CST and its relevancy (Benwell and Rhys 2018) to the medical agenda. The CST observed in our data supports the problematic distinction between on/off-task talk. At the heart of our analysis is the institutional relevancy of talk to the medical tasks. In other words, the nature of the encounter (holistic medicine for older adults) within which types of talk are nestled determines the extent to which CST can comfortably emerge into 'big' talk. While attending to the trouble, we argue that CST also accomplishes serious medical tasks for providing patient-centred care: identifying disease-causing factors, providing diagnosis, offering solutions and advice, and most importantly, understanding the patient as a whole person. As Coupland (2000a) notes, many of the health problems of older adults are attributable to their life circumstances and family connections. Therefore, talk at this level is an important medical resource. This is particularly the case in holistic medicine such as TCM, which treats the human body as a complete entity and 'pays more attention to the diseased patient rather than the disease' (Luo *et al.* 2013: 305). In encounters like this, the distinction traditionally held between small talk

and professional talk becomes rather blurred. The extensive troubles-telling sequence in our data manifests an attentiveness to (i) the troubles-teller (the patient) and her experience and (ii) medical problems (poor sleep and anxiety) and their properties (Jefferson and Lee 1981). The analysis we present here also suggests a troubles-telling quality embedded in CST that distinguishes it from other constructs of small talk.

A notable finding in our analysis relates to the turn design in the troubles-telling sequences in medical interaction. A consistently observed feature is ambiguity. There are many instances when the doctor displays an ambiguous orientation towards both medical tasks and troubles-telling by employing different language devices, for example, the token confirmation/backchannel 'ou' (Extract 2), the short non-problematic reformulation of the patient's trouble (Extract 3), and building medical evaluations upon the patient's trouble presentation (Extract 6). We consider that ambiguous orientation (Jefferson 1988) allows the doctor to engage in troubles talk while proceeding with medical tasks. Such ambiguity is also observed in patient turns, particularly in an environment where silence is observed or where the doctor indicates an orientation to medical tasks. In the wake of such activities, the patient initiates statements that indicate both the social and institutional identities, pivoting between attending to trouble and core medical tasks. We also observe interactional organization where the patient often orients to the trouble whenever the doctor displays an ambiguous orientation.

The findings reported here thus contribute to a better understanding of small talk in medical encounters. While many of the previous studies in this field concentrate on small talk in Western medical encounters, we present a different context where small talk constitutes a crucial part of the medical agenda, serving as an integral component of the session. Instead of being discouraged, curtailed, or disattended, it is encouraged and co-constructed by the doctor to seek pathological explanations for the patient's disease while performing other social functions (e.g. showing empathy). We contend that a number of factors are ramified here—the co-topical nature of the talk, the dual relevance to both the task and the trouble, and the context within which talk is enveloped—allowing for the appropriate evolution of CST into extensive troubles-telling without disrupting the medical agenda. These findings can help practitioners and clients better understand the nature of medical communication in holistic encounters such as TCM and how it might differ from conversations in other medical practices. In that sense, our findings have practical implications for both clinical and discourse studies and would be particularly insightful for communication between professionals from different clinical practices. The analysis could also be illuminative to other contexts where participants are given the capacity to embed problems into narratives such as conversations about death and dying (Pino and Parry 2019), recovering from and adapting to serious illness (Wowk 1989), and talk on counselling helplines (Danby and Emmison 2014). The findings might be less applicable to

contexts such as acute care or emergency calls where highly specialized, concise, and goal-oriented talk is the norm.

NOTES

1 The inconsistency in gender pronouns is a result of the phonological homogeneity in three different person pronouns in Chinese, namely 'it', 'he', and 'she'. Such homogeneity might cause misunderstanding in conversation.

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