CHAPTER 14

Ad Hoc Inquiries: Two Preferences in the Design of Routine Questions in an Open Context

John Heritage

In the United Kingdom, community nurses visit all newly delivered mothers within a few days of their return from hospital. These visits occur without regard to the social or economic status of those visited and, though they occur at the mother's homes, they are often initiated without prior consent. They are nonetheless rarely refused. During these initial visits, the nurses—known as health visitors—begin to build a relationship with the mother that, ideally, will be deepened over the course of many others. The health visitors will attempt to establish a "befriending" relationship in which their professional expertise will be acknowledged and put at the disposal of the mother. They will also collect standardized information about the family and its circumstances, which they record on the spot. This chapter looks at how the health visitors design their *routine* questions in search of standardized information.

The conduct of the health visitors in this situation may offer us a glimpse of how social surveys may have been administered in the past. The origins of the health visitor service are rooted in the same historical and ideological context as the school board visitors, whose information formed the basis of Charles Booth's *Life and Labour of the People in London* (Booth, 1889–1903). Moreover, like the social surveys conducted before World War II, the routine information solicited in these visits is not collected by means of questions whose wording is determined in advance. Like the prewar "schedule" or "blank" (Converse, 1987:33–34), the

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form that the nurse must complete is a printed ("clinic") form that contains spaces, or slots, for relevant items of information concerning other family members, age, occupation, nationality, and siblings, and basic information concerning the course of the pregnancy and labor. And, like the blanks, the clinic form does not contain any specific wording for the questions to go with those slots. This circumstance offers an opportunity to see how the nurses, charged to administer routine questions on standard topics, design those questions when they have the latitude to vary them in ways that are not constrained by the requirements of survey methodology.

This chapter begins with a discussion of the context in which these questions are asked and answered. Specifically, it looks at how the task of completing the child health form is constructed by the nurses, and how it is positioned relative to the other business that is normally transacted in the nurse–mother encounter. Second, focusing on questions about (a) the child's birth and health postpartum and (b) the parents' age and occupation, it examines two preferences that the nurses consistently deploy in designing questions: (i) to embody a preference for normalized or *optimized* states of affairs and (ii) to design the questions in the light of information and other interactional dimensions of the interaction-in-progress so as to exhibit *recipient design*.

The chapter's central observation is that, regardless of the specific aims of questioning, the ways in which questions are designed unavoidably serve to index particular relationships between questioner and respondent. At one extreme is the kind of questioning found in the survey interview, designed to minimize bias and maximize the objectivity and standardization of results. This style of questioning, if reciprocated in the respondent's answers, constitutes a social relationship in which both parties treat their specific identities for one another as irrelevant for all practical purposes. This relationship may be termed "essentially anonymous." If questioners want their relationships with respondents to depart from this condition, then departures from the effort to maximize the neutrality and objectivity characteristic of survey question design will have to be made. This chapter discusses the departures that are recurrent when medical personnel, concerned with building personal relationships with new mothers, engage in *face sheet* and related standardized questioning.

DATA AND ITS CONTEXT

In the occasions that we will focus on, first-time mothers and their new babies have been discharged from hospital in the previous several days and are receiving their first visit from the health visitor. The visit is normally unannounced and, on one or two occasions, the mothers were caught somewhat unprepared for the visit.

With the knowledge and permission of all parties, 5 health visitors (HVs) audiotaped a series of 6 visits to a total of 9 first-time mothers, and another 10 mothers of second or subsequent babies.[1] The recordings were made in a large British midlands city and in households varying significantly in occupation and income. This is, of course, not a large sample of the hundreds of thousands of visits made by HVs to new mothers each year. Nor is the sample representative. These weaknesses would be problematic if we were attempting to assess the distribution or frequency of the activities going on in these visits. However, the task in this chapter is a more restricted one: to identify features of question design in this context and to suggest underlying principles that organize them. While the data are definitely adequate for this purpose, it is clear that they cannot yield anything like a full sampling of these features, and this chapter makes no pretense at any kind of exhaustive catalog.

BACKGROUND: THE HEALTH VISITORS AND THEIR ROLE

The British health visitor service is the largest single element of the UK community nursing program, comprising some 9300 qualified nurses (Cumberlege Report, 1986:10). The health visitor's role, as described by the Health Visitors' Association (1985), is to be "fully and completely involved in the giving of advice and support but only indirectly in the treatment of illness, environmental control and the provision of practical help." As this broadly worded description suggests, health visitors have very wide-ranging professional responsibilities comprising the detection and prevention of ill health in the community, the identification of health needs in the community, health teaching, and advice and guidance in cases of illness and in the care and management of children (Council for the Education and Training of Health Visitors, 1977). These responsibilities — in which advice giving plays a primary role — are discharged through verbal interaction with members of the community. Unlike community nurses in other advanced countries, British health visitors do not perform routine nursing tasks and concentrate instead on illness prevention, giving advice on health and social problems and case finding for other more specialized agencies.

The British health visiting service is distinctive in that, unlike other medical services in the United Kingdom and elsewhere, its provision is supply — rather than demand — driven. This characteristic is particularly prominent in relation to the health visitor's work with children. Health visitors have a statutory obligation to perform routine visits to all mothers with children under five regardless of whether these visits are requested or not.[2] The supply-driven character of the service reflects the origins of the health visiting service in the municipal sanitation movement of the nineteenth and early twentieth century. This movement was highly interventionist and was anchored in a sense of mission that bordered on a moral crusade.[3] While this explicit moral focus has all but evaporated with the health visitor's incorporation into an instrumentally oriented national health service, there remains a — perhaps irreducible — residue of ambivalence concerning the dual role of advisor and evaluator that is commonly attributed to the health visitor role (McIntosh, 1986).

During the home visits, HVs generally act as baby experts while also striving to construct a warm, befriending relationship (Heritage and Sefi, 1992; Heritage and Lindström, 1998; Robinson, 1982; Sefi, 1988). However these efforts are not

by any means always successful. A substantial proportion of mothers, particularly those in poorer socioeconomic circumstances, see the HV service largely in terms of social control and surveillance and attempt to minimize contact with its representatives. Most surveys suggest declining levels of satisfaction with the HV service over time and indicate that mothers tend to remain unclear about the role and value of HVs. These studies also indicate that mothers have a strong preference for friendliness and informality in HV conduct and that HVs are quite commonly perceived as excessively authoritarian and didactic (McIntosh, 1986).

GENERAL CHARACTER OF THE FIRST VISITS

Of the visits that make up our database, most represented the first occasion on which the mother and HV had met one another and, although the mothers were expecting a visit from the HV at some time during the week of the first visit, all were unannounced.[4] In six of the nine visits making up our database, the new mothers were not alone when the HV called. In two cases, a female companion was also present: a young female friend in one case, and the mother's mother (with whom the couple were living) in the second. In the other four cases, the new father was present. In most of the visits, these other persons were significant, sometimes even dominant, participants. The visits varied in length from 15 minutes to just under an hour.

Although the visits are quite diverse, their content contains a number of common features. A large majority of topics were initiated and terminated by the HV in a basically *segmented* process of topical progression (Button and Casey, 1984; Sefi, 1988). Substantial parts of these first visits were occupied with three significant bureaucratic tasks: (1) getting face sheet data about the mother and baby for the records of the clinic to which mother and baby will be attached; (2) getting consent signatures for immunization injections for diphtheria, whooping cough, tetanus, polio and measles; and (3) explaining clinic procedures and the various subsequent health checks that mothers and babies will go through in the ensuing months and years. The visits were substantially diverse in terms of their overall trajectories, the type and ordering of the topics raised, and in terms of the tone or rapport achieved between the parties.

GETTING ROUTINE DATA: THE QUESTIONNAIRE SECTION OF THE ENCOUNTER AS OBSTACLE AND RESOURCE

The main body of routine information that the health visitor must gather is laid out as a block on the second page of a form labeled Child Health Record, which is conveniently color coded, pink or blue. The main block that the health visitors

Parents

	Nationality	Year of Birth	Occupation
Mother	**Item # 1**	**Item # 2**	**Item # 3**
Father	**Item # 4**	**Item # 5**	**Item # 6**

Siblings[1]

Name	**Item # 7**				
Sex					
D.O.B.					

Birth information

Pregnancy normal/abnormal, specify **Item # 8**

Type of delivery **Item # 9**

In S.C.B.U. Yes/No **Item # 10**

Neonatal problems 1 **Item # 11** 2 _____ 3 _____

Feeding on leaving hospital Breast/Bottle/Mixed **Item # 12**

Family planning advice given Yes/No

Figure 14.1

have to complete in the visits we recorded is represented in Figure 14.1. There are 12 information items in the form that we focus on, which are numbered for reference purposes.

In principle, this information can be quite straightforward to obtain, as the following extract illustrates. The father was not present during this interaction.

(1)[5A1 : 9][6]

```
 1  HV:  And Andrew's (.) j[ob?                                  Item # 6
 2  M:                       [Painter and decorator.
 3       (1.7)
 4  HV:  So his- (.) he hasn't come into his own yet'as he=
 5  M:   =No:=
 6  HV:  =in the hou:se.
 7  M:   No[:.
 8  HV:     [((co[ ugh)) ('is:)
 9  M:      [(Not) ye:t.
10       (0.2)
11  M:   His ti:me will come (.) yeah.
12       (1.0)
13  HV:  Has he got plenty of wo:rk on?
14  M:   He works for a university college.
15  HV:  O:::h.
16  M:   So: (.) he's in full-time work all the ti:me.
17  HV:  °Yeh.°
18       (0.4)
19  HV:  And this is y'r first baby.                             Item # 7
20  M:   Ye(p).
21  HV:  And you had a normal pregnancy.=                        Item # 8
22  M:   =Ye:h.
23       (1.5)
24  HV:  And a normal delivery,                                  Item # 9
25  M:   Ye:p.
26       (1.8)
27  HV:  °That's (great)°
28       (0.7)
29  HV:  And sh'didn't go into special ca:re.                    Item # 10
30  M:   No:.
31       (1.8)
32  HV:  °A:nd she's bottle feeding?°                            Item # 12
33       (1.2)
34  HV:  °'nd° (0.5) and uh you're going to Dr.White
35       for your (0.6) post-natal?
```

Here, in a very few turns at talk, the HV addresses 6 out of the 12 main items of information she is required to obtain.

However, while this *questionnaire section* of the visit can be managed quickly and easily, it was often treated as a source of difficulty (Heritage and Sorjonen, 1994). Set within a visit that is substantially aimed at relationship making with the family — and, in particular, befriending the mother — the questionnaire section is often portrayed as embodying the intrusion into the visit of an alien set of relevancies. For example, the health visitors may initiate the questionnaire section as an onerous task to be disposed of at a convenient moment:

(2) [4B1:2]

```
Well whi(le) she's asleep we might as well fill in these forms and get
them over and done with.<
```


(3) [4A1:7]

```
He's terrific. .hh Well while he's so settled and quiet (0.6)
maybe it would be a good idea to get (.) a:ll the paperwork
over and done with.
```

Or they may give the forms they are completing a functional gloss:

(4) [4B1:17]

```
This is his baby clinic card >you could keep it< (.) it's uhm
we keep at the health center its just (0.5) we put the dates
of the injections (0.7) uh:m any information there that's relevant,
(1.2) and the weight, (2.2) his date of birth where he was born
how many weeks gestation, (1.0) and on this side, (2.5) uh:m
> information about the parents< you're both British?
```

Or simply attempt to minimize the intrusiveness of the questions:

(5) [1C1:25]

```
Okay so that's that's your clinic fo:rm...An' all I put on here
is you:r (0.7) there's a bit about you: (0.7) it sa:ys here that
you're twenty one is that ri:ght?
```

Finally, they may distance themselves from questions that seem particularly bureaucratic or outside the range of relevancies of the visit:

(6) [4A1:13]

```
These details (.) I don't know why they want to know but
father's a:ge.
```

(7) [4B1:5]

```
Uh:m (0.5).hh now fi:rst th' particulars they want to know th' baby's
father's a:ge.
```

In these and other ways, the health visitors treated the *clinic form* section of the encounter as problematic and as in contrast to the main purpose of the visit.

However, in some of the home visits the clinic form represented a resource. In these cases, the forms were invoked early and their contents were treated as an agenda of inquiries that could be elaborated upon, or departed from and returned to in due course. This use of the clinic form was prominent in cases where fathers were present. In this context, the health visitors used the clinic form as a resource to legitimate questions, and associated topical lines, which mainly focused on the mother's experience and tended to exclude fathers from participation. A return to the clinic form, and its bureaucratic details, was also used as a means to reinclude fathers in the conversation in ways that were legitimately provided for and did not seem forced or unnatural.

This use of the form is illustrated by the following extended sequence:

(8) [1A1:12-22]

```
1 HV:   So this'll be her clinic ca:rd.
2       (1.0)
```

```
 3 HV: →  (.hh) And on here we have a record (0.8) of how you
 4        were in- (0.3) did you have a normal pregnancy:?      Item #8
 5  M:     Yes.
 6        (0.7)
 7 HV: →  I'll ring no:rmal. And what about your delivery,
 8        (1.6)
 9 HV:    Did you (0.6) uhm have a normal delivery,=did         Item #9
10        you wat[ch it.
11  M:           [Ye::s
12  F:    Mm hm,
13 HV: →  Did you?=What did you thi:nk. ((smile voice))
          ...
          ... [ Approx. 2.5 minutes of talk that focuses on difficulties
          ... in getting the baby's shoulders out during the delivery.]
          ...
160 HV: → =So you had a- uh: (1.0) You didn't- Did you-
161       You didn't have forceps you had a:                    Item #9
162  M:    =Oh [no:: nothing.
163  F:        [( )
164 HV: →  An- and did she cry straight awa:y.                  Item #11
165  M:    Yes she did didn't sh[e.
166  F:                         [Mm hm,
167       (1.0)
168 HV: →  Uhm (.) you didn't go to scbu: you know the
169       spe[cial care unit.                                   Item #10
170  M:       [Oh: no: no:.
171       (0.8)
172 HV:   °Good.°
173       (0.5)
174 HV:   So the hospital: are quite pleased with her.
175       (0.5)
176  M:    Mm::.
177       (2.0)
178 HV: →  And you breast fed straight away did you:?           Item #12
179  M:    Ye(p).
180       (1.2)
181 HV: →  °And she hasn't had a bottle yet.°                   Item #12
182       (0.7)
183 HV:   °Good.°
184       (0.7)
185 HV:   S[o-
186  M:     [She'ad- (.) she'ad water the first night,
187       (0.8)
188  M:    uh-=
189 HV: →  =Are you working.                                    Item #6
190  F     Nope.=
191  M     =No.
192       (1.5)
193 HV:   (   )
194       (1.0)
195 HV:   So you're unemplo:yed,
196  F:   Mm hm,
197 HV:   .tch Poor you. What did you used t'do.
          ...
```



```
          ... [Approx. 4.5 minutes on F's employment problems]
          ...
405 HV:   Ri:ght.
406       (4.5)
407 HV:   Uh::m (1.5) >Where did we get to.<
408       (2.0)
409 HV: →  How old are you father?                              Item #5
410       (0.7)
411  F:    Twenty si:x.
412       (4.7)
413 HV: →  Were you a uhm (1.5) what (1.0) uh: (.) you were a
414       nurse at the Randolph.                                Item #2
415  F:    Ye[h
416  M:      [Yea:h.
417       (5.2)
418 HV:   Uhm (.) an S.E.N..
419  M:    Ye(p).
420       (2.2)
421 HV:   Are you going to go ba:ck.
422  F:    Mm hm
423  M:    Yea:h
424  F:    ((sniff))
425  M:    I've taken maternity leave.
426 HV:   ([   )
427  M:    [I'm due to go back in Ma:rch.
428 HV:   And who will look after (.) Ann-Marie.
429  M:    I was goin' back on nights.
430 HV:   I see.
431  M:    I wanted to'ave a go at a couple of nights to
432       see if we could (.) you know manage between us,
```

In this case, the health visitor takes about 11 minutes to cover the same ground that was covered in about 30 seconds in the first example. But, in the interim, she has gone out of her way to involve the father in a discussion of the delivery (starting at lines 9–10), has addressed the father's employment difficulties and the family's associated financial problems (lines 197–404), and explored the mother's employment plans and provision for baby care (lines 417–432).

In sum, routine data collection in these interactions represented both a source of difficulty and of opportunity, depending on the context. In interactions with mothers on their own, it was treated as an unequivocal intrusion into the encounter, and as something to be minimized as far as possible. In interactions where others were present, the form filling was sometimes treated as problematic, but it was also deployed as a resource in the management of the interaction to include both mothers and fathers, while legitimating lines of questioning that might otherwise be treated as excluding fathers from the interaction.

QUESTION DESIGN

Regardless of whether the nurses treated routine data collection as an intrusion or as a resource, the questions by which they implemented the process did not

resemble traditional questionnaire questions. Two fundamental principles underlay the nurses' questions. These principles are drawn from the normative order of everyday life and clearly depart from the principles informing questionnaire construction and implementation. They are: (1) the principle of optimization, which yields questions designed to prefer "best-case," normal, or "no-problem" responses;[7] and (2) the principle of recipient design, which yields questions adapted to the specific circumstances of a recipient, and the state of the interaction between questioner and recipient that is current at the moment of the question.

BIRTH DETAILS: QUESTIONS EMBODYING THE PRINCIPLE OF OPTIMIZATION

Questions that embody the principle of optimization display a respect for what Maynard (in press) terms the benign order of everyday life. They do so by incorporating presuppositions and preferences that are biased toward best-case or no-problem outcomes, and they are a characteristic feature of medical questioning in a great variety of routine contexts (Boyd and Heritage, in press). For example, in questioning patients about their family history, doctors will rarely spell out a full range of potential options. Thus a question about parental mortality could be asked in at least the following ways:

Is your father alive?
Is your father dead?
Is your father alive or dead?

However, it is overwhelmingly asked in the first, best-case form, which is designed for, and thus prefers a confirming "Yes" response. The second method of asking this question — "Is your father dead?" — which would favor a confirming bad news response, is not ordinarily used outside of some aspect of the recipient's circumstances that would make its production specifically accountable. But neither is the third, objective, or bureaucratic, form of the question ordinarily deployed in medical contexts (Boyd and Heritage, in press).

In the data we are examining, the nurses' questions about the process of childbirth are almost uniformly constructed so as to favor optimized no-problem responses. A very clear case is the following in which, while a series of yes/no declarative questions varies in terms of the polarity preferred, each is constructed in search of a no-problem response:

(9) [5A1]

```
1 HV:     And this is y'r first baby.                    Item #7
2  M:     Ye(p).
3 HV: →   And you had a normal pregnancy.=               Item #8
4  M:     =Ye:h.
5         (1.5)
6 HV: →   And a normal delivery,                         Item #9
7  M:     Ye:p.
```



```
 8         (1.8)
 9 HV:     °That's (great)°
10         (0.7)
11 HV: →   And sh'didn't go into special ca:re.          Item #10
12  M      No:.
13         (1.8)
14 HV:     °A:nd she's bottle feeding?°                  Item #12
15         (1.2)
16 HV:     °'nd° (0.5) and uh you're going to Dr.White ...
```

A similar pattern of questions favoring no-problem responses emerges in the following sequence, at lines 1, 4, 11, 14, 16, 19 and 20:

(10) [4A1:17]

```
 1 HV: →   Uh::m (.).hh So your pregnancy was perfectly   Item #8
 2     →   normal.
 3  M      Yeh.
 4 HV: →   And did you go into labor (.) all by yourself? Item #9
 5  M:      No: I was started o[ff because uh:m (0.8) the blood
 6 HV:                         [Induced.
 7  M:     pressure (0.7) went up in the last couple of weeks.
 8         ...
 9         ... [Segment dealing with why mother was induced]
10         ...
11 HV: →   And was he alright when he was born.          Item #11
12  F:     Mm[:.
13  M       [Yeah.
14 HV: →   He came down head fi:rst.                     Item #9
15  F:     Mm h[m,
16 HV: →       [No:rm- no:rmal delivery?=                Item #9
17  M:     =Ye:h.
18         (2.2)
19 HV: →   And did he stay with you all the time.=       Item #10
20     →   =He didn't go to special care baby unit.
21  M:     No:.
```

Here each question thematizes the medically and socially desirable outcome of labor as the focus for a yes/no question. In each case except the last, the question design favors a "yes" response, sometimes abandoning interrogative for declarative syntax in pursuing this objective (lines 14, 16, 19, and 20), and/or deploying negative polarity when a "no" response is the best-case, no-problem one (e.g., line 20).

It is very rare that any of these questions are asked in a form that provides explicit alternatives (the "alive or dead" option). The only such case in this data set is the question "And didju: (0.6) push her out yourself or did you have to have forceps (then)" in the following sequence (at lines 11–12):

(11) [1C1:25]

```
1 HV:     Didju have a normal pregnancy:.                Item #8
2  M:     Yes a very goo:d pregnancy:.=I carried her we:ll.
3         (1.2)
4 HV:     A:nd uh: (1.5) how long were you in labor for the:n,
5         (1.0)
```

```
 6  M       Uhm thirteen to fourteen hou:rs.
 7          (1.0)
 8 HV:      W'll that's pretty: average actually for a first
 9          baby:,
10          (1.2)
11 HV: →    And didju: (0.6) push her out yourself or did      Item #9
12     →    you have to have forceps (then).=
13  M:      =Pushed her out mese:lf.
14          (4.2)
15 HV:      And she: (0.5) cried straight awa:y-               Item #11
16          (0.5)
17 HV:      D[id she:?
18  M:       [No:
19  M:      She didn't no (it took'er (0.3) couple'v minutes
20          actu'lly)=
21 HV:      =Yeh,
22  M:      They had to give'er uh:: (.) she come out blue:
23          (0.4) the:y gave he:r oxygen I think it was a
24          minute before she cried,
25 HV:      Yeah.
26          (0.6)
27 HV:      But she didn't have to go to: (.) special ca:re   Item #10
28          unit or any[thing.
29  M:                 [No:: no:.
```

Subsequent to this question, the nurse reverts to declaratively formed questions shaped in favor of no-problem responses. Notably the "B-event" question (Labov and Fanshel, 1977) at line 15 "And she: (0.5) cried straight awa:y-" is revised with an incremental, tag question (line 17) in the face of deferred response by the mother. Here the deferral of the response projects a "No" answer that aligned against the design of the question, and the later description of a problem that the question was not built to favor. However, even after the mother's account of her baby's initial postpartum difficulties (lines 19–24), the nurse's question about the special-care baby unit is still declaratively shaped to favor a no-problem response (lines 27–28).

As already noted, these question designs carry forward a more general tendency in ordinary conversation for good news to be favored over bad news, and for interaction to be conducted under the auspices of the "benign order of everyday life" (Maynard, in press). As Houtkoop-Steenstra and Antaki (1997) have also suggested, questions designed to favor problematic responses are "marked" forms that are accountably asked only "for cause" and must be licensed by information from prior talk or its context (see also Boyd and Heritage, in press). We can see this kind of license emerging in the following sequence, where the nurse picks up a hesitation in the mother's response to an earlier no-problem inquiry:

(12) [4A1:19]

```
1 HV:   And you're feeling well.
2       (0.7)
```



```
 3  M:   Yeah.
 4       (1.5)
 5 HV:   And you're- (.) You didn't ha- Did you have stitches?
 6       (0.8)
 7  M:   Ye[:es
 8 HV:     [You did. [('N) are you so:[re=
 9  M:               [(nh hnhn )      [I had a third degree tea:r=
10 HV:   =O::::::h. ↑Did you::?
11  M:   Yeah. (0.2) It's uh (.) they think what happened'is
12       chin must'ave caught me.
13       (0.3)
14  M:   .hhh as'e w'[z coming ou:t.
15 HV:               [O::::h,
```

While it is open as to what the term "feeling well" might address in the inquiry that begins this sequence, the declarative question itself is clearly designed for an optimized no-problem outcome. However, the mother's response is both minimal and quite delayed (line 2). Perhaps because of these features, the nurse abandons a next question "And you're-" (line 5), that was begun as a move to a new *agenda* item (Heritage and Sorjonen, 1994) and instead moves to what is hearable as a contingent inquiry addressed to the whether the mother had stitches. This question is initially designed toward a no-problem outcome "You didn't ha-." However, this declarative question form is abandoned, and revised to an interrogative form "Did you have stitches?" which, relative to the declarative at least, favors what will be in this context a more problematic "Yes" response.

A similar case is the following. Here the nurse's question follows an extensive sequence in which both parents described the difficulties the mother experienced during labor with the child's shoulders. While the delivery process they describe was lengthy, they did not mention the deployment of any unusual measures (such as forceps). The nurse's question resumes her work of completing the child health card, and addresses item 9, "Type of delivery," in which the recording of a forceps delivery would be clearly relevant — see excerpt 11, lines 11–12. The initial form of the nurse's question at line 1 would probably have eventuated as "So you had a normal delivery" as the upshot of that account.

(13) [1A1:14]

```
 1 HV:   =So you had a- uh:
 2       (1.0)
 3 HV:   You didn't- Did you- You didn't have forceps      Item #9
 4       you had a:
 5  M:   =Oh [no:: nothing.
 6  F:       [(   )
 7 HV:   An- and did she cry straight awa:y.               Item #11
 8  M:   Yes she did didn't sh[e
 9  F:                        [Mm hm,
10       (1.0) ((Wood cracking))
11 HV:   Uhm (.) you didn't go to scboo: you know the     Item #10
12       spe[cial care unit.
13  M:      [Oh: no: no:.
```

However, instead of taking her initial formulation of this question to its likely conclusion ("So you had a normal delivery"), the nurse abandons it at just the point at which the optimized word "normal" would be due, in favor of a question design that will come to address the possibility of forceps more explicitly. This new question, however, with its invocation of a problematic circumstance that was not previously referenced, causes her notable difficulty. She begins with a declarative form "You didn't-" that would likely favor a no-problem report. Abandoning this, she reinitiates her question with an interrogative form "Did you-" that, as in except 12, would be more favorable to a problematic response. Finally she reverts to a fuller declarative form favoring a no-problem outcome: "You didn't have forceps you had a:" Here it seems likely that the full question that the nurse was heading toward was "You didn't have forceps you had a normal delivery." However, once again, the nurse abandons the question at the point at which the word "normal" was due. In this case, the nurse was clearly in genuine doubt as to whether her question should be framed so as to favor a no-problem response, or whether in the light of the parents' description of a difficult birth process, she should depart from this norm toward a less upbeat question design.

OCCUPATIONAL DETAILS: QUESTIONS EMBODYING THE PRINCIPLE OF RECIPIENT DESIGN

At the most fundamental level, the prospect of standardizing the questioning of patients is interdicted by the principle of recipient design. This term refers to the "multitude of respects in which the talk by a party in a conversation is constructed or designed in ways which display an orientation and sensitivity to the particular other(s) who are the coparticipants" (Sacks, Schegloff, and Jefferson, 1974:727). It is, of course, considerations of recipient design and, in particular, the issue of whether a no-problem question design would be appropriate given what the mothers had conveyed or stated, that impacted the somewhat vacillating question designs we have already seen in excerpts 12 and 13.

The principle of recipient design is very apparent in the nurses' questioning about the details of parental nationality and occupation. For example, in the following case, the nurse (who visited the mother briefly just before she had her baby) is clearly oriented to the impropriety of asking redundant questions. Thus at line 2, her question about the parents' nationality (items 1 and 4) is built to presuppose that they are British nationals. Similarly, having asked about the mother's occupation (lines 27–35), she acknowledges having been told this on a previous occasion at line 37. It can also be noticed that, having asked the mother her boyfriend's name (line 7), the nurse "volunteers" his family name at line 9, based on previous knowledge that the mother is taking the boyfriend's family name (see also line 14):

(14) [5A1:8]

```
1 HV:  (pt) °N(h)o:w° jist need a little bit of (0.3)
2      information on the insi:de.=You're both British.  Item #1 & 4
3      (0.6)
```



```
 4  M:  Yeah.=
 5 HV:  ° Yeh.°
 6      (2.8)
 7 HV:  What's your boyfriend's name?
 8  M:  Andrew.
 9 HV:  Andrew.(0.2) Beetham.
10  M:  Yeah.
11      (3.0)
12 HV:  You're Mary.
13  M:  Yeah.
14 HV:  °Beetham°.
15      (1.8)
16 HV:  And uh (.) his date of birth=his a::ge?                Item #5
17      (1.0)
18  M:  He's twenty-one so what would his date of birth be.
19(?):  hhhhhh=
20  M:  =six-
21 HV:  Twenty one'll do:.=
22  M:  =Yeah.
23 HV:  =They can work it out from the[:re huh
24  M:                                  [Yeah
25      (0.2)
26 HV:  fr'm there.
27 HV:  Were you working?                                      Item #3
28      (.)
29 HV:  Previous[ly?
30  M:          [Yeh I wa:s.
31 HV:  What were you doing?
32  M:  Uhm General Infirmary.
33      (0.7)
34  M:  Housekeeping.=
35 HV:  =Housekeeping.
36      (.)
37 HV:  That's ri:ght °(I remem-)°
38      (2.8)
39 HV:  And Andrew's (.) j[ob?                                 Item #6
40  M:                    [Painter and decorator.
```

The nurse's treatment of these two questions embodies an orientation to the mother as someone with whom she is forming a relationship. In such a context, failure to remember significant details about the mother is accountable. The nurse treats herself as accountable for remembering them, and in this way she indexes an ongoing, if only nascent, relationship with the mother. Her treatment of these questions contrasts quite markedly with her pursuit of face sheet data about the mother's boyfriend (lines 7, 16, and 39) whose details are treated in a more anonymous fashion characteristic of the survey interview. Comparing the questions about the mother and the boyfriend suggests that the latter embody what might be termed 'legitimate ignorance' about the subject matter. Thus, the boyfriend's details are treated in a more anonymous fashion, which is characteristic of the survey interview.

In other cases, nurses find other ways to use questions to assert an incipient relationship with the mothers. For example, they question them by supplying candidate answers to their questions:

(15) [3A1:8)]

```
 1 HV:    Ehm, so (I-) anyway I'll fill'is- I'll finish filling
 2        this card in..hhh Eh:m (0.7) father's age at bi:rth.
 3        (0.5)
 4  M:    He's twenty nine.
 5 HV:    °Twenty nine.°
 6        (1.2)
 7 HV: →  And he is a builder.
 8        (1.5)
 9  M:    °Y:up°
10        (1.3)
11 HV: →  And um: (.) you were (.) anaesthetic's nurse weren't
12        you.
13  M:    Yep.
14 HV:    And dj- (0.2) Do you think you'll (.) be a housewife
15        now for a bit.
```

(16) [1A1:20]

```
 1 HV: →  Were you a uhm (1.5) what (1.0) uh: (.) you were a
 2     →  nurse at the Randolph.
 3  F:    Ye[h
 4  M:      [Yea:h.
 5        (5.2)
 6 HV:    Uhm (.) an S.E.N..
 7  M:    Ye(p).
```

The preference for this form of question design shows up in the fact that it carries the risk of error:

(17) [3B1:24]

```
 1 HV:    >I'd better fill in the rest of this ca:rd then,
 2     →  .hh ↑Mothers occupa:tion it- that was catering
 3        wasn't [it,
 4  M: →          [No no::.=(I'm in) pottery teaching.
 5        (.)
 6 HV:    [Ah:
 7  M     [Pottery teacher.
```

Nonetheless the imperatives of relationship making mandate this form of recipient design, notwithstanding the risks.

Some of the nurses' questions are, of course, less presumptive, but this does not mean that the significance of recipient design is thereby diminished. In the next two cases, the nurses approach the question of the husband's occupation in distinctive ways:

(18) [4A1:12]

```
 1 HV:    These details (.) I don't know why they want to know
 2        but father's a:ge.
 3        (0.9)
 4  M:    heh Twenty eig[ht
 5  F:                  [Twenty eight [I (should think)
 6  M:                                [>heh heh heh [heh huh
```



```
 7 HV:                                                [Twenty eight.
 8  M:    .hhuh
 9  F:    (Short a week (   ))
10        (1.0)
11 HV: →  And your occupation?
12  F:    °(P'lic' f's)°
13 HV:    Uh::(h)::r hhh[eh heh heh huh huh
14  M:                  [heh heh heh heh
15  F:    Don't say it like that.
```

(19) [1A1:16]

```
 1 HV: →  =Are you working.
 2  F     Nope.=
 3  M:    =No.
 4        (1.5)
 5 HV:    (    )
 6        (1.0)
 7 HV:    So you're unemplo:yed,
 8  F:    Mm hm,
 9 HV:    .tch Poor you. What did you used t'do.
```

While the nurse's question in excerpt 18 presupposes that the husband is currently employed, the question in excerpt 19, which also looks more like a survey question, does not. As it turns out the design of both these questions reflects the operation of recipient design and, in both cases, the presumption (or the lack of it) that the nurse makes turns out to be correctly fitted to the local environment. In except 18, the father has already made reference to the fact that he is on paternity leave for 2 weeks and, in this context, the question "Are you working?" would evidently be redundant. In the second case, the father has made no such reference and a more cautious, and less presuming, approach to the topic of employment is the more appropriate one.

DISCUSSION

The British health visitor service, from which these data come, is a state-sponsored remnant of the municipal sanitation movement of the nineteenth century. Developing as part of a middle-class response to the squalor of working-class housing in Britain's mid-Victorian cities, the movement culminated in the development of a national sanitory inspectorate early in the twentieth century. The women inspectors' duties of a century ago are clearly evoked in the following quotation from the rule book of the Manchester and Salford Sanitory Association (c.1880):

> They must visit from house to house, irrespective of creed or circumstances, in such localities as their superintendents direct. They must carry with them the carbolic powder, explain its use and leave it where it is accepted; direct the attention of those they visit to the evils of bad smells, want of fresh air and impurities of all kinds; give hints to mothers on feeding and clothing their children; where they find sickness, assist in promoting the comfort of the invalid by personal help they... must urge the importance of cleanliness, thrift and temperance on all possible occasions. They are

> desired to get as many as possible to join the mothers' meetings of their districts: to use all their influence to induce those they visit to attend regularly at their places of worship, and to send their children to school. (Clark, 1973:11)

It is just these kinds of women, including most importantly the school board visitors of the period, who were the source of most of the information recorded in Charles Booth's (1889–1903) monumental and pioneering exercise in survey research, *Life and Labour of the People in London*. As these women moved from house to house, gathering information in the neighborhoods to which they were assigned and with which they were familiar, it is difficult to believe that they did not employ questioning of the type we have seen in this chapter, embodying principles of optimization and recipient design. Furthermore, it seems likely that this questioning was interlinked with sequences in which they built rapport with their subjects, supporting their reported decision making and experiences, as in the following sequence:

(20) [4A1:17]

```
 1 HV:    Uh::m (.).hh So your pregnancy was perfectly
 2        normal.
 3  M:    Yeh.
 4 HV:    And did you go into labor (.) all by yourself?
 5  M:    No: I was started o[ff because uh:m (0.8) the blood
 6 HV:                        [Induced.
 7  M:    pressure (0.7) went up in the last couple of weeks.
 8        (2.2)
 9  M:    I was going in the G.P. unit until two weeks
10        befo[re he was bo:rn,
11 HV: →     [O:h what a pity.
12        (.)
13  M:    and then uh.hh the blood pressure went up,
14 HV:    M[m.
15  M:      [so I had him in the consultant's,
16 HV:    Yes.
17        (0.2)
18  M:    a week early.
19 HV: → Oh well that was rather nice you didn't have to wait
20     → quite s[o   [long.
21  M:           [N(h)[o(h):::.
22  M:     .hhh hnh (.) mm[:
23 HV:                    [And was he alright when he was born.
```

In this kind of conversational interviewing, the interviewer morally supports the interviewee, endorsing decisions she has made, sympathizing with unfortunate outcomes, and otherwise "looking on the bright side."

A similar kind of interactional process is recorded for survey interviews in societies where social surveys are not yet commonplace and institutionalized. In a recent study of Czech interviewing, for example, Jana Hoffmannová (1998) identifies a range of strategies that interviewers use to maintain rapport with their subjects, including praising, sympathizing, agreeing, and identifying with the interviewee. In the following sequences, concerning the interviewee's (IE's)

vacation travel plans, the same interviewer (IR) explicitly supports each IE's standpoint on foreign travel, though these standpoints are somewhat opposed:

(21) [Hoffmannová, 1998:163]

```
1 IR:  Where are you going this year?
2 IE:  This year we're planning to go to Greece.
3 IR:  Greece is beautiful. I've been there before.
4 IE:  Well I hope it works out.
5 IR:  It's good to travel and look at different countries.
```

(22) [Hoffmannová, 1998:163]

```
1 IE:  We've been to the West two or three times to have a
2      look. But now the excitement's beginning to fade.
3 IR:  Not when we've already seen it before.
4 IE:  No, not when we've already seen it.
5 IR:  The shops are the same everywhere.
6 IE:  Exactly.
```

One sees here something of the same effort at relationship building and above all personalizing the interview relationship, as is readily apparent in the British health visitor data.

It is clear, I think, from these examples that the principles of optimization and recipient design as features of question construction in these data are fundamental to the process of making and sustaining personal relationships with particular other individuals. There is no "time out" from this process for anyone who is intent on sustaining such a relationship, regardless of whether its basis is professional (as in these data) or more personal. From this vantage point, we can begin to see what a peculiar social relationship is instantiated in the survey interview. It is a relationship from which optimization is excluded and in which, save for the use of *filter questions*, recipient design is systematically avoided. In the survey interview, both interviewer and interviewee must collaborate in the construction of an essentially anonymous relationship from which all personal characteristics that could be acknowledged in the design of a turn are rigorously excluded. This is a social relationship that most of us have little or no experience of outside the special province of the survey interview. It takes effort to sustain and, as several contributors to this volume document, can easily break down. Indeed it has taken upwards of 50 years for the survey interview as a form of social interaction to become institutionalized to the point that most of the population can collaborate in its co-construction without the kind of discomfort or collapse into conversation that Hoffmannová and others have documented.

The distinguished physician Eric Cassell (1985:86) observes that medical questioning must address much more than the patient's current condition: The doctor must also find out

> who the patient is, and how the kind of person the patient is, along with how he or she behaves, interacts with the pathophysiology to produce this specific illness. Next must come an attempt to discover whether other factors, environmental, familial, social, occupational, or personal habits, have played a role in making the patient sick.

To accomplish this, physicians employ a relatively standardized list of questions and become, as Cassell (1985:89) puts it, "a fixed measuring instrument," a kind of living questionnaire, neutral and consistent across patients. However, despite Cassell's observations, it is clear that medical personnel do not question in the style preferred in social surveys. While more formal or objective question designs might, in principle, minimize response bias, this consideration is offset by the need to put patients at ease and permit relationship building. These latter considerations mandate the implementation of norms of questioning from the everyday world, particularly optimization and recipient design. Thus in medicine, as in other walks of life, there may be a trade-off between objectivity on the one hand and the effort to build human bonds on the other. In this process, the effort after objectivity, at least in the strictest sense, is not often the winner. Indeed it may be hazarded that, as Weber (1948) contended, the effort at objectivity is only a dominant impulse in bureaucratically administered activities of which, perhaps, the survey interview is a supreme expression.

NOTES

1. This work was done in collaboration with Sue Sefi.

2. Although the health visitor has a statutory obligation to cater to the health needs of all children, she does not have a statutory right of entry into the parental home. In practice, however, the accountability of denying entry to the health visitor renders such a right unnecessary.

3. See Robinson (1982) for a summary account of the historical background to this unusual division of labor between health visitors and other community nurses and Donzelot (1980) for an account of the ideological background of health visiting.

4. Although the HV service stresses the value of establishing contact with mothers before the birth of a baby and efforts are normally made to do so, only one HV in our sample had in fact made contact with her two first-time mothers prior to the first recorded visit.

5. This item, while potentially multiple, is treated as a single item because all the mothers in the data set discussed here were first-time mothers. The issue of siblings could, therefore, be disposed of in a single question, as in excerpt 1.

6. In these transcripts all proper names, including those of towns, corporations, and other institutions, are pseudonyms.

7. For accounts of preference organization, see Heritage (1984), Pomerantz (1984), Sacks (1987), and Schegloff (1988).

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CHAPTER 15

Standardization vs. Rapport: How Interviewers Handle the Laughter of Respondents During Telephone Surveys

Danielle Lavin and Douglas W. Maynard

Survey researchers seek to measure subjects' past and intended future behaviors, their attitudes, beliefs and values, and their membership in social categories (Schuman and Kalton, 1985:643–652). Furthermore, as Fowler and Mangione put it (1990:14), the "key defining part of a measurement process is standardization."[1] Of course, both practitioners and critics of the survey recognize that interviewers and respondents construct answers during interaction, and that standardization cannot be uniform or absolute (Maynard and Schaeffer, this volume, Chapter 1). Practitioners and critics differ, however, in what the constructed nature of interview data means, with practitioners asserting that validity is not necessarily compromised. When standardization is unable to screen nonsampling error, for instance, researchers are able to investigate and remedy normative *context effects* and other influences on response patterns (Schuman, 1982; Schuman and Ludwig, 1983). Critics, on the other hand, argue that the survey interview is inherently distorting and that we need altogether alternative forms of interviewing (Cicourel, 1982; Mishler, 1986; Suchman and Jordan, 1990), including those that are more *conversational* in structure (Conrad and Schober, 2000; Schober and Conrad, 1997).

Although this controversy has an interesting history (Beatty, 1995; O'Muircheartaigh, 1997), we do not take a position on it. Rather, taking for granted that survey interviewing involves *construction* and some *negotiation* between

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