BUREAUCRATIC AUTHORITY IN THE "COMPANY OF EQUALS": THE INTERACTIONAL MANAGEMENT OF MEDICAL PEER REVIEW*

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I examine the negotiation of treatment decisions and the management of professional relationships during medical peer review. Using audio recordings of reviews conducted by telephone, I examine three recurrent interactional junctures in the review: (1) the reviewer's formulation of an initial request for information about the patient; (2) the doctor's immediately subsequent description of the patient; and (3) the reviewer's announcement of a decision about the appropriateness of the proposed procedure. Through the practices that accomplish these actions, doctors and reviewers orient to tensions between collegial and bureaucratic pressures, and manage these tensions through a set of interactional and institutional resources that may minimize the potential challenge to the collegial relationship. In doing so, the participants work to preserve the ideal of professional autonomy, even while it may be compromised by the review process itself.

The potential for conflict between bureaucratic and collegial forms of control has been a concern in sociology since Weber's (1946, 1947) formulations of the organization of authority. Many studies of the professions, however, have emphasized the extent to which this potential is minimized: The work of professionals is insulated from bureaucratic control and is regulated instead through informal, internal mechanisms. As argued by Parsons (1947:58–60), and later by Freidson and Rhea (1963:185), the members of a profession properly work as a self-regulating "company of equals." Within the medical profession, as a number of empirical studies have shown, physicians' clinical judgments are independent of the administrative requirements of the hospital or clinic (e.g., Abbott 1988; Bosk 1979; Freidson 1970, 1975; Freidson and Rhea 1963). Thus the physician's primary work—the detection, diagnosis, and treatment of illness—has long been characterized as autonomous and free from external control. Freidson (1975) observed that

> . . . the day-to-day work of doctoring goes on without the exercise of direct administrative controls. No rules and regulations specify how doctors should work, and no administrative supervisor gives them orders. . . . The concrete work of providing service remains controlled, if controlled at all, by professionals. (Pp. 10–11)

In the past 20 years, however, many of medicine's traditional institutional arrangements have undergone fundamental change. Increasingly competitive conditions and growing pressures to contain health care costs have forced providers to alter the structure and organization of health care delivery systems. Third-party payers (such as state gov-

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ernments and private insurance companies) now have a direct financial interest in the provision of services to patients (Freidson 1989; Gray 1991:5; also see Scott 1982), and utilization management programs have established the widespread use of protocols or standardized criteria as a basis for deciding appropriate medical therapy (Freidson 1989; Gray 1991).

These changes challenge previous understandings of medical practice and force a reexamination of the medical profession. The doctor-patient relationship remains primary, but it is no longer the *only* relevant medical relationship. Increasingly, treatment decisions are made outside the examining room, in accordance with administrative regulations or in consultation with external reviewers representing third-party payers. The result is an increasingly rationalized form of medicine, in which the physician's traditional autonomy is eroded and the conventional boundaries between bureaucratic and collegial control are blurred (e.g., Gordon 1988; also see Berg 1996).

I examine the negotiation of treatment decisions and the management of collegial relationships in the medical peer review[1]—an environment in which issues of bureaucratic regulation and professional autonomy are central. Stated most simply, peer review involves the evaluation of one physician's clinical recommendation by another physician for reimbursement purposes. In this setting, the complexity of the relationships between collegiality and bureaucracy, between past arrangements and present constraints, between interactional and institutional pressures, is most evident.

My focus on issues of bureaucratic authority and professional relations within the medical profession is not abstract; rather, I consider these issues as they emerge and are managed by physicians during actual peer reviews. By focusing on the interactional details of the review and on the specific practices used by the interactants in managing its relevancies, I offer more than a singular description of the context of peer review; I also provide an examination of the actual social processes through which the profession of medicine is organized.

The content and structure of doctor-patient interactions have been the subject of numerous empirical studies (e.g., see Anspach 1993; Fisher and Todd 1983; Frankel 1984; Heath 1986; Maynard 1991; Mishler 1984; Silverman 1987; Strong 1979; Waitzkin 1991; West 1984), but the processes of *interaction among physicians* have not been investigated (Freidson 1989; but see Anspach 1993; Atkinson 1995; Bosk 1979; Cassell 1991; Good 1995; Millman 1976). As Atkinson (1995) observed, there is little sociological understanding of the "interactions—some fleeting and informal, others more formally contrived—through which medical practitioners consult one another" (p. 34).

The peer review is one such "formally contrived" occasion; during this review, patients' histories are described, clinical findings are reproduced, appropriate treatments are determined, and professional relations are instantiated.

PEER REVIEW

Some forms of utilization review have existed since the 1950s, but peer review as a specific form of professional control was not widely implemented until the 1970s (Palmer and Gill 1977), when professional standard review organizations (PSROs) organized groups of physicians to monitor the hospitalization of Medicare patients by geographic region (Scott 1982). Though the goal was to minimize differences in the costs and quality of care across the country by implementing standardized treatment criteria, the recruitment of local physicians to participate in the planning and administration of these organizations was an acknowledgment of the importance of self-regulation in the medical profession. According to Scott (1982), "[T]he hope [was] that physicians' collegial norms [would] be harnessed, [thereby] aug-

[1] The terminology used to describe the various cost-containment strategies of managed care is quite inconsistent (Gray 1991); generally, programs involving prior authorization of specific procedures (such as the program I describe here) are known as utilization management or utilization review programs. I use the term *peer review* here to capture the intracollegial character of the review—specifically, the fact that the reviewer is a fellow physician. See Gray (1991) for a useful discussion of terminology and techniques of utilization management.

menting the legitimacy of the control system" (p. 220).

Peer review has gained widespread acceptance by health care purchasers and payers, and is the cornerstone of many managed care programs (Gray 1991; Scott 1982). In most forms of utilization or peer review, a physician's recommendations are evaluated by comparing the details of a specific case with a set of criteria predetermined to be appropriate indicators for a particular clinical procedure (Scott 1982). For instance, the RAND/UCLA method, employed by the utilization review firm represented in this study, involves a set of criteria based on the compiled recommendations of a national panel of clinical experts (Brook et al. 1986; Kleinman et al. 1994). These criteria then are applied case by case, by physician-reviewers representing the utilization review firm.

The peer review process, of course, entails an inherent tension: By enlisting physicians to evaluate the actions of other physicians, thus "augmenting" the legitimacy of the review (Scott 1982), the peer review requires professionals to violate their own norms of autonomy. In this paper, I examine the specific practices whereby this tension is manifested and managed. Using audio recordings of peer reviews conducted by telephone, I examine three recurrent interactional junctures in the review process where issues of collegial and bureaucratic conflict are most relevant: (1) the reviewer's formulation of an initial request for information about the patient; (2) the doctor's immediately subsequent description of the patient; and (3) the reviewer's announcement of a decision about the appropriateness of the proposed procedure. Through the practices that accomplish these activities, doctors and reviewers orient to tensions between collegial and bureaucratic pressures and manage them through a set of interactional and institutional resources that may minimize the potential challenge to the collegial relationship. In doing so, the participants work to preserve the ideal of professional autonomy, even while it may be compromised by the review itself.

The first of these practices, the reviewer's formulation of an initial request for information, has consequences for the rest of the review. In this request, the reviewer proposes certain alignments and relevancies; whether these are accepted, rejected, or resisted, they set trajectories for subsequent courses of action. Subsequent actions, such as the announcement of a decision, thus are designed and responded to "against the backdrop" of the formulation that launched the review. This opening formulation, then, is a critical point in the developing talk as the reviewer proceeds to the "business" of the call.

At least since Goffman's (1971) work on access rituals, the opening sequences of interaction have been shown to be especially important across an array of settings, both institutional and ordinary. As described by Schegloff (1986), the opening turns of ordinary telephone conversations are interactionally critical: At this point, the parties work through issues of identity, recognition, and topic initiation. Through their opening turns of talk, parties establish whether, how, and for how long they will engage in a sustained episode of interaction, constitute their identities and relationship for the present interaction, and manage initiation of the intended topic or "reason for the call" (Schegloff 1986:113). In short, the type of conversation that is being opened, including relevant identities and relationships, is constituted by the parties to the conversation in the first utterances (Schegloff 1979:25).

Establishing identities and alignments is an issue not only for interactants in ordinary telephone conversations. In numerous institutional settings, interactants work to establish the "grounds" for the ensuing interaction. For instance, Maynard (1984) found that the openings of plea-bargaining sequences had sequential implications in that the openings offered recipients positions with which to align. Further, the negotiational work of the subsequent session varied according to the acceptance or rejection of the alignment proposed initially. Clayman (1991) and Roth (1997) described the importance of the opening description of interviewees in broadcast news interviews for establishing relevant identities and alignments within the interview. Whalen and Zimmerman (1987:182) showed how participants in 911 calls worked to establish appropriate identities through the opening sequences in emergency calls to the police. In doctor-patient interaction, Heath (1981), Frankel (1995), Coupland, Robinson, and Coupland

(1994), and Robinson (forthcoming) have described the importance of the doctor's first question to the patient in eliciting the patient's reason for the visit.

In the peer review, the reviewer's initial formulation of a request for information about the patient is the first step in aligning the participants along primarily bureaucratic or collegial lines. As I show here, these alignments have consequences for the entire review, helping to constitute an interactional environment in which particular actions are accomplished more or less easily. In particular, the more "collegial" the initial formulation, the more difficult it may be for the reviewer to deliver—and the doctor to accept—a negative decision.

DATA AND METHODS

The data consist of 108 audiotaped telephone discussions between 13 board-certified physician-reviewers, contracted by a utilization review firm to conduct prospective reviews for surgical interventions, and 108 specialists (10 pediatricians and 98 otolaryngologists) who have recommended surgery to insert tympanostomy tubes into children's ears. The audio recordings were made as part of the record-keeping routine of the utilization review firm, and all of the doctors were aware of the recording. Names and identifying characteristics have been changed.

All of the patients for whom surgery was proposed suffered from some form of *otitis media*, a condition characterized by infection and buildup of fluid in the middle ear. Otitis media is the most commonly diagnosed ailment in children (Kleinman et al. 1994) and is often treatable with a 10-day course of antibiotics. The surgical insertion of tympanostomy tubes into the ears is an alternative, routine treatment, although recently it has drawn criticism. According to some researchers, antibiotic treatment is equally effective and is neither as invasive nor as costly as surgery (Bluestone and Klein 1990). As part of an overall strategy of cost containment, some health plans now require certain standards of prior treatment to be met before reimbursement for tympanostomy.[2] Gathering information on such prior treatments, as well as on clinical symptoms, is the focus of the peer review studied here.

The sample of 108 reviews was randomly drawn from a population of 942 physician-reviews for tympanostomy conducted between April 1990 and July 1991 and stratified by the type of appeal available[3] and the relative volume of cases handled by each reviewer. I oversampled low-volume reviewers to increase reviewer variability. I also stratified the sample by outcome or decision: 71 cases were approved for surgery, 31 cases were denied, and in 6 cases the decision was deferred pending confirmation. This proportion approximated the organization's overall approval/denial rate for tympanostomy cases.

I transcribed the calls according to the conventions developed by Jefferson (Sacks, Schegloff, and Jefferson 1974; also see Atkinson and Heritage 1984; Appendix A), and analyzed them according to the methods of conversation analysis (Drew and Heritage 1992, chap. 1; Heritage 1984, chap. 8; Schegloff 1987). Briefly, conversation analysis is concerned with the analysis of naturally occurring interactions (Schegloff 1987) and with the situated social practices embodied in participants' talk.

THE REVIEW PROCESS

The review process described here is prospective: Cases that fail the review would not be reimbursed by the patient's insurance company and the tympanostomy probably would not be performed. The review process begins with an interview between a nurse-reviewer and a member of the office staff of the otolaryngologist proposing the procedure. Cases that fail this first-level review are then passed to a *physician-reviewer* who interviews the otolaryngologist (the case doctor) and gives the case "last chance" con-

[2] The Agency for Health Care Policy and Research (AHCPR) also has issued national guidelines for the appropriate use of tympanostomy tubes in children. See Kleinman (1996) for a comparison of appropriateness criteria used by AHCPR and in private utilization review.

[3] Stratification by this variable was motivated by an interest in the relative rates of recommended surgeries for each category of insurance company. It is not significant for the focal point of this study.

sideration.[4] At this point, the physician-reviewer can consult the "paper trail" from the first-level review—a computer-generated list of the interview results and any handwritten notes taken by the nurse-reviewer. The doctor being reviewed has the patient's clinical record available but may know virtually nothing about the first-level review, the review process, the criteria used to judge the case, or the status of his or her case. In most instances, reviewed doctors know that the insurance agency requires additional information about the patient; but most are unaware that the case has failed to meet the criteria of the first-level review.

During the review, the case doctor consults the patient's medical record to answer the reviewer's questions about symptoms, diagnosis, and treatment. The reviewer then compares the case doctor's answers with the formal criteria. To determine a surgical status for each case, the reviewer considers factors such as the child's age, the presence of fluid in the ear (effusion), the frequency and/or duration of effusion, the amount of hearing loss, type(s) of antibiotic treatment(s) tried, the presence of learning or developmental difficulties, and several specified exceptional circumstances (such as cleft palate).

After hearing the patient's history, the reviewer makes a decision about the appropriateness of the surgery. If the criteria are met, the procedure is recommended as medically necessary and is subsidized by the patient's health plan; cases that are denied are not subsidized, and the surgery is not likely to be performed. During this interaction, then, the reviewer decides whether the case doctor's judgment is appropriate, given the particular circumstances of the case as described.

THE BUSINESS OF THE REVIEW: MANAGING CONFLICTING PRESSURES

As discussed earlier, the very "business" of the review may be a source of interactional tension, representing an unwelcome intrusion for many private practitioners. Outside of training environments or disciplinary situations, the clinical judgment of individual physicians is rarely subjected to professional inquiry. As independent practitioners, most doctors do not evaluate or criticize their colleagues' work and do not expect to be evaluated by them (Freidson 1970, 1975). The very premise of peer review, however, rests upon the possibility of a challenge to professional judgment. The doctor proposing surgery faces the immediate possibility of challenge because the reviewer will render explicit judgment on the doctor's decision. This judgment may have significant consequences for both the patient's treatment and the doctor's economic and professional well-being. Equally at risk, however, is the reviewer, whose competence, credentials, and loyalty to the profession may be called into question by a doctor who sees the review as a constraint on his or her professional autonomy. In the review process, this tension is made manifest in three ways.

First, in determining the terms on which the review proceeds, both participants make choices between institutional roles or types of alignment in relation to each other and to the review itself. The reviewer, whose initial concern is to launch discussion of the case, may choose between at least two alternative institutional roles. On one hand, the reviewer may propose to align with the case doctor as a colleague, displaying an orientation to the institutional relationship as one between *physician*-reviewer and fellow doctor or specialist (i.e., otolaryngologist and otolaryngologist). On the other hand, the reviewer may emphasize the bureaucratic or administrative nature of the review, situating the participants as physician-*reviewer* and doctor-under-review. In response, the case doctor may embrace or resist these proposed alignments and the understandings of the encounter they entail. In any given instance, the selection of one of these alternative relationships seems to be oriented, at least in part, to a shared understanding by the participants of the imposition represented by the review itself.

Second, tensions may be generated by conflict between the bureaucratic requirements of the review and local, clinical knowledge as competing bases for treatment decisions. The primacy of clinical experi-

[4] During the period under study, approximately 30 percent of the 5,214 reviewed cases failed the first-level review and were eligible for physician review.

ence or expertise over "scientific" knowledge (Becker et al. 1961; Cassell 1991; Freidson 1970) has long been considered an inherent value of the medical profession. Clinical experience is gained only through the actual experience of treating patients (Gordon 1988) and is precisely the feature that distinguishes the members of the medical profession from other professions: It incorporates the specialized knowledge and technical skills that constitute the profession itself (Freidson 1970). Also, it is largely incompatible with explicit, standardized, rationally based rules and criteria (Gordon 1988).

In the case doctor's response to the initial request and in the subsequent question-answer sequences that form the discussion portion of the review, I observe differing orientations to the relevance of these types of knowledge to the decision to perform surgery. Doctors "making a case for surgery" often invoke firsthand knowledge of the patient; that practice, however, may introduce factors that are incompatible with the reviewer's standardized criteria. The source of the tension, then, is the potential for conflict between the particulars of a case (as described by the case doctor) and the generality of the criteria against which it will be judged.

Finally, rendering a judgment entails its own risks and tensions, particularly for the reviewer. In many ways, the complexity and the importance of the relationships between institutional role, professional norms, and interactional concerns culminate in the announcement of the decision (and especially a negative decision). In announcing a decision, the reviewer's actions reveal the dilemma represented by the review: To issue any decision involves a violation of professional norms; to appeal to bureaucratic standards and criteria denies (or at least subordinates) the relevance of the case doctor's local knowledge of the patient and the authority of his or her clinical judgment; to appeal to shared professional understandings potentially undermines the authority of the review process itself. Thus the announcement of a decision involves an intricate negotiation of alignment as the reviewer prevails on the case doctor to accept the final decision.

BUREAUCRATIC VERSUS COLLEGIAL INITIATIONS: THREE PRACTICES FOR INITIATING DISCUSSION OF CASES

Through the design of the questions that initiate the discussion of a case, the reviewer offers a first characterization of the review as well as a proposed alignment of the two participants. In doing so, the reviewer makes relevant particular subsequent actions by the doctor and shapes (at least partially) the trajectory of the review. With very few exceptions,[5] reviewers use three practices to initiate the first topic or to undertake the business of the call: (1) bureaucratically focused initiations, (2) consensus-building initiations, and (3) collegial initiations. Each practice offers the doctor particular structural opportunities (Schegloff 1991) in describing his or her case, and each is oriented, at least partly, to the management of bureaucratic constraints and collegial relations.

Bureaucratically Focused Initiations

In the bureaucratically focused initiation, the reviewer's initial request for information about the patient characterizes some documentary or clerical aspect of the case as problematic. Typically it contains a reference to some inconsistency, omission, or other problem, as recorded in the first-level review, or with the reviewer's understanding of the case. Either explicitly or through a formulation that projects it, the reviewer indicates the presence of an administrative problem. In Extract 1, the reviewer characterizes his information about the patient's history as incomplete, conflictual, and therefore problematic. (In the following extracts, D is the case doctor being reviewed; R is the reviewer; arrows indicate phenomena of interest. See Appendix A for description of transcript notation.)

The reviewer begins with the information about the patient that he *does* have—the patient's age and diagnosis (lines 1–2). In

[5] In eight instances, the reviewer's initial request is preempted by the doctor, who immediately begins to describe the patient. The relevance of the "missing" request is considered elsewhere (Boyd 1997).

Extract 1

```
 1   R:    The information I have is he's six an'-=with a
 2         history of recurrent uh otitis and (0.1) uh
 3      -> I think 'e had previous tubes, (0.5) but according
 4      -> to the information we got from a Doctor (Katz),
 5      -> (.) the pediatrician's o[ffice,
 6   D:                            [Uh huh.
 7         (.)
 8   R:  -> He has uh- (0.2) they i- I don't get any
 9      -> documentation of any problems at all in the last
10      -> year.
11         (.)
12   R:    And I- from their office
13         [so I wanted to check with you.
14   D:    [Uh huh.
15   D:    'et's see uh. (0.4) I saw 'im on thirty May
16         ninety one,....                          (6190: August 7, 1991)
```

line 3, however, when he contrasts the information he has (gathered during the first-level review) with the information from the pediatrician's office (that the patient has not been seen recently), he indicates the presence of a problem: Although the child has a history of effusion and previous tympanostomy tubes, the pediatrician has not seen the child in the past year. The juxtaposition of apparently conflicting information amounts to a problem with the case, but the reviewer casts the problem as a bureaucratic matter (and not, for instance, as a problem with the doctor's judgment). At line 8, the reviewer stops to change his utterance-in-progress (see Schegloff, Jefferson, and Sacks 1977) and to reframe the problem explicitly as one of documentation, ending with "I don't get any documentation of any problems at all in the last year" (lines 8–10). Through this "self-repair" (Schegloff et al. 1977), the reviewer avoids explicitly comparing the information from the pediatrician's office with the doctor's information. Instead the comparison is cast in terms of the documentation the reviewer has been able to acquire.

Overwhelmingly, bureaucratically focused initiations project a problem with the case, but problems are consistently cast as ones with the existing record or with the reviewer's understanding of the record. In other words, the problem originates from bureaucratic concerns, namely meeting the standards of the formal criteria and the review process.

In Extract 2, the reviewer has information that seriously undermines the doctor's recommendation for surgery (in relation to the criteria): The patient's hearing has tested normal; therefore her problem is not severe enough to warrant tympanostomy tubes. The reviewer's bureaucratically focused initiation, however, does not describe these adverse considerations directly; instead the reviewer formulates the problem as an issue of documentation.

In this instance, the reviewer initiates discussion of the case by characterizing his own knowledge about the patient: "Actually I don't have too much information here" (line 5). This preface projects a possible problem with the distribution of information between the two participants, but not with other aspects of the case—for instance, the doctor's diagnoses or actions. Upon completion of this unit of talk (see Sacks, Schegloff, and Jefferson 1974 on "turn constructional units"), the reviewer has yet to formulate a specific problem. Not until line 8, marked with the contrastive "but," does the reviewer begin to specify the problematic aspects of the case: He possesses information—the normal hearing test—that challenges the appropriateness of the surgery according to the criteria.[6] Though the patient has an acknowl-

[6] According to the criteria, a normal hearing test renders the recommendation for surgery equivocal at best, regardless of the length of the effusion and the number of antibiotic treatments.

Extract 2

```
 1   R:    I'm Doctor Grayson and I'm
 2         reviewing Michelle Ravine for tubes?
 3   D:    Mmhm.=
 4   R:    =You may hear a beep=We record our calls.
 5      -> (0.2) And (.) actually I don't have too much
 6      -> information here=this uh=I have- I know she's four,
 7      -> (0.1) and she's had uh history of an effusion,
 8      -> (0.2) but the information I have is that she's
 9      -> recently had a hearing test which was normal.
10         (0.2)
11      -> R:And uh- and I know she's had an effusion but
12      -> I don't know how long it's been documented for.
13   D:    Wh- what- (.) when did she have a normal
14         hearing test?
15   R:    I don't have the date,=it just says here hearing
16         test within normal limits. [hh An' I don't know if
17   D:                              [(M-)
18   R:    that was ju[st-
19   D:               ['Cause we did an audiogram on th' hh
20         ninth of April which was .hhh abnormal.
21   R:    Oh. Okay, (0.3) uh what di- could you tell me what
22         the-=how much-=uh loss there was?
23         (0.2)
24   D:    Well she hh .hh (.) is uh twenty an' twenty-five
25         decibel levels in the low tones.  h
26   R:    Okay. Alright.=Yeah I'm- I'm (.) glad you corrected
27         that. .hh Do you know how long she's had this
28         effusion?=                                  (2222: April 22, 1991)
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edged history of effusion (line 7), the normal hearing test suggests a less severe problem and thus raises an issue of accountability for the doctor: How to account for the proposed surgery in light of the normal test.

In the absence of a response from the doctor at a point where a response is relevant (the .2-second silence at line 10), the reviewer introduces a second problem. Though he acknowledges the existence of an effusion, he focuses his question on the documentary evidence of its duration. The doctor's response (lines 13–14) returns to the issue of the hearing test and challenges the *reviewer* to account for conflicting information.

In this fragment, the substantive problem with the case is treated by the reviewer as a matter of information distribution; in the final formulation of his request (lines 11–12) he explicitly invokes documentation as the relevant issue (as he does in reissuing the question in lines 27–28). The doctor's task, then, is to address a problem of *incomplete documentation* rather than to directly account for his own actions in light of the reviewer's contradictory information.

In sum, by framing the issue to be discussed in terms of a documentary or informational problem, the reviewer may avoid initially implicating the doctor's professional judgment, thereby minimizing the potential threat of the review. The reviewer's stance emphasizes his or her bureaucratic status in relation to the doctor and proposes to align the participants along bureaucratic lines. Questions about the facts of the case may be treated as matters of administrative record (or as the reviewer's understanding of the case) to be reconciled according to the requirements of the criteria.

Consensus-Building Initiations

In consensus-building initiations, the initial request for information is preceded by reference to known and (at least for the reviewer)

Extract 3

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 1   R:  -> Uh Okay we're calling you on uh right on uh Margot?
 2          (0.2)
 3   D:     °Yeah.°
 4   R:  -> .hh A five-year-old uh young lady I guess with uh some
 5          p- prior history of uh (.) middle ear problems?
 6   D:     °Yeah.°
 7   R:  -> An' she had prior tubes uh back in (0.2) wha'
 8          was 'at uh (.) May of eighty nine?
 9   D:     Yeah. Yeah. She had tubes also in- (.) seven.
10   R:     In eighty seven also okay. She's had two sets o'tubes.
11      -> Okay now uh the question that I was gunna ask was
12          (0.2) does she (now) have a recurrent effusion?
13          (0.4)
14   D:     Yes.=
15   R:     =Okay, uh any idea as to how long 'e they- they
16          possibly have been there?                    (1949: September 17, 1990)
```

presumably undisputed aspects of the patient's history, particularly the patient's age and diagnosis. Through the design of preliminary sequences, the reviewer works to enlist the doctor's agreement over particular details of the case. In Extract 3, the reviewer asks a series of questions about details of the patient's history of ear problems.

The reviewer begins by offering a series of statements for confirmation or agreement: The identity of the patient (line 1), her age and gender, the nature of her problem (lines 4–5), and her history regarding tympanostomy tubes (lines 7–8). The questions in lines 1, 4–5, and 7–8 are formulated like "B-event statements" (Labov and Fanshel 1977)—declarative utterances in which the speaker (the reviewer) formulates the history as something of which the recipient (the doctor) has authoritative knowledge. These utterances cast the doctor as the knowledgeable party, the reviewer as less knowledgeable, and at the least, make confirmation or denial relevant in the recipient's next turn (Heritage and Roth 1995:10). The reviewer does additional work here to cast himself as less knowledgeable than the doctor, employing qualifiers such as "I guess" (line 4) to characterize his uncertainty and using grammatical and intonational resources to convey the dates as estimated, ". . . wha' was 'at uh May of eighty nine?" (lines 7–8). All of these devices work to indicate the tentative character of his knowledge of the patient.

The doctor's minimal confirmations (lines 3, 6, 9) display an orientation to the reviewer's questions as seeking confirmation but not elaboration. Similarly, each next turn of the reviewer offers another increment in the patient's known history rather than pursuit of the prior answer, and the sequential progress of the review continues. Furthermore, the questions are marked as questions in a larger sequence of inquiry, which contributes to the sense that they are routine and background in nature (Heritage and Sorjonen 1994)

At line 11, the reviewer explicitly marks a shift in his line of questioning. Retroactively, he casts what came before as preliminary to the question or questions he had intended to ask all along. First he marks the shift in action with "Okay" (see Beach 1993; Jefferson 1981); then he says explicitly, "the question that I was gunna ask was. . . ." The remainder of the review focuses on the length of the effusion—the subject of the "intended-all-along" question.

By preceding the "intended question(s)" with information about the patient that is already known and presumably is uncontested, the reviewer minimizes the possibility that he will be heard as questioning the doctor's judgment. That is, by structuring his initial turns for confirmation or agreement (Sacks 1987; Schegloff 1988), the reviewer launches the business of the review with actions that bring himself and the doctor into alignment over certain aspects of the case. In

doing so, the reviewer (at least initially) may minimize the potentially threatening aspects of the review by casting the case from the outset as a matter about which they largely agree. By the time they "get to" the problematic aspects of the case—here, the presence and length of effusion—they can proceed from a position of agreement (however minimal that may ultimately prove to be).

In addition, through the consensus-building initiation, the reviewer displays an orientation to the doctor as the primary source of knowledge about the patient. In designing his questioning turns as requests for confirmation, the reviewer preserves the primacy of the doctor's firsthand knowledge of the patient's history, and (at least indirectly) acknowledges professional norms of conduct that inhibit the usurpation of one doctor's authority by another (see Freidson 1970, 1975). Furthermore, the reviewer's questioning turns incorporate qualifiers and mitigators such as "I guess," "I understand," and "I was wondering"; all of these index the relative distribution of knowledge and preserve the doctor as the primary authority on the patient's status and history.

In contrast to the bureaucratically focused initiations, which refer consistently to documentary issues, consensus-building initiations culminate in questions that directly address the doctor's knowledge of or actions with the patient. The potential interactional challenge of this approach, however, is mitigated by the agenda-like character of the preliminary questions leading up to those questions, and by the position of agreement that immediately precedes for the question. Thus, consensus-building initiations represent a compromise or "middle position" from which the reviewer works to bring the parties into alignment or agreement over implicitly bureaucratic matters. As its name suggests, the consensus-building initiation proposes to be affiliative, even while issues are raised concerning the doctor's actions or knowledge regarding the patient. Again, in contrast, the bureaucratically focused initiation explicitly formulates the concern with bureaucratic or documentary information and avoids overt reference to the professional relationship between the two doctors.

On the other hand, both the consensus-building and the bureaucratically focused initiations limit the boundaries of accountability to specific information. That is, through the design of the preceding sequences and the final question or set of questions, general documentation or specific clinical information (such as a treatment date) is established as the relevant domain, the issue of concern. The review thus is framed as a matter of collecting and/or documenting information rather than as an evaluation of the doctor's decision to perform surgery. In contrast, collegial initiations offer no such topical constraints or resources.

Collegial Initiations

The collegial initiation is formulated as a general, unimposing inquiry about the patient, with no mention of an existing problem, "facts" to be confirmed, or documentary issues at stake. Instead, the collegial initiation invites the doctor to identify the most relevant features of the case.

Both previously described formulations framed the upcoming review in terms of specific clinical or documentary information; collegial questions are designed to be general and apparently unimposing. In Extract 4, the formulation, "Can you tell me something about this youngster?" (line 1), first, mitigates the imposition of the question by formulating the action as a request rather than a

Extract 4

```
1  R: -> .hh Uh can you tell me something about this youngster?
2        (0.6)
3  D:    Uh well okay. Euh he has a hearing loss
4        that dates back (.) to (0.6) what date is this one
5        here girls? What date is that? (2.0) HA! Waitamin.
6        (.) Six. (.) No. Okay six five eighty nine is when
7        he was referred to us by family physician for
8        questionable hearing loss....          (8462: February 12, 1991)
```

Extract 5

```
 1   R:     ...( )- (Taylor) McConell.
 2   D:     Okay,=
 3   R:     =.hhh Uh eh- (0.2) could you tell me something
 4          about this y-=uh youngster?
 5   D:  -> She's oh about fifteen months old now,=
 6   R:     =Uh h[uh,
 7   D:  ->       [°°or thirt[een months old.°° um (.) with
 8   R:                      [.hhh ((clears throat))
 9   D:     recurrent ear infections.=She's had uh approximately
10          five ear infections or six ear infections in the first
11          twelve months of life, (0.2) uh she's been treated
12          with amoxicillin, uh with resolution, (0.4) She
13          continues to have um (.) recurrent ear infections,
14          she's on prophylactic antibiotics.        (1326: October 18, 1990)
```

as command (see Ervin-Tripp 1976; Goodwin 1990 for directives in conversation); second, it defines the topic to be addressed as a nonspecific "something"; third, it characterizes the patient with the age category term "this youngster." The use of an age category instead of the child's exact age (available to the reviewer from the paper trail) marks the age category as a general reference, particularly because the patient's exact age is relevant to the criteria. Indeed, the case doctor may respond to the generality of this categorical reference term, as in Extract 5.

In Extract 5, the reviewer initiates discussion of the case in a fashion effectively identical to that in Extract 4—describing the patient with the categorical reference term, "this youngster." Here the case doctor's initial response implicitly contests that reference: The doctor replies with a more precise specification of the patient's age (lines 5 and 7) and indicates that the patient is an infant. As Sacks (1992:1966) and Schegloff (1993) both observed about the use of different measurement systems in ordinary conversation, one formulation is not simply a less precise version than the other. Rather, alternative formulations are designed to be fitted to specific actions. For the doctor in this example, the child's exact age (in months) is relevant because (as we can see retrospectively) an appreciation of the severity of the child's disease rests, in part, on the frequency and duration of her problems (that is, for 12 of her 13 months of life, lines 10–11). Similarly, the reviewer's use of the categorical age term is designed to be heard as general, not agenda-based, again in keeping with the unimposing, noninstitutional character of his initiating request.

In each of its features, the collegial request for information is designed to minimize the imposition of the inquiry itself and to offer the doctor maximum latitude in designing a response. At the same time, the review is characterized as not agenda-based (cf. Heritage and Sorjonen 1994 on the agenda-based character of certain institutional interactions). In this respect, the collegial initiation can be seen as collegial *by design* insofar as the utterance does not invoke the relevance of the formal criteria, does not narrow the domain of possibly relevant clinical issues, does not identify some problem to be addressed, and does not refer in any way to the agenda-based character of the review. Instead the collegial initiation, at least on its face, proposes to align the participants as two physicians discussing a case. That is, the reviewer's enacted status as a colleague (a fellow physician), made clear in the opening self-identification sequences, proposes this general inquiry as collegial.[7] Ironically, however, this collegial opening may set the interaction on a trajectory that ultimately is anything but collegial.

In sum, then, through the design of initiating actions, reviewers propose to align with case doctors along lines that emphasize the bureaucratic or agenda-based character of

[7] These features embody aspects of the distinction between bureaucratic and collegial control, as described by Freidson (1989).

the review (i.e., the bureaucratically focused initiations), its collegial nature (i.e., the collegial initiations) or some combination of the two (i.e., the consensus-building initiations). Yet as the consensus-building initiations imply, the relationship established between bureaucracy and collegiality is not simply dichotomous; rather, both doctors' actions constitute a complex and contingent relationship. The design of the initiating question may propose a particular alignment, but that alignment may be embraced, rejected, or contested in the doctor's subsequent turn(s).

RESPONSES TO INITIAL REQUESTS: LOCAL VERSUS BUREAUCRATIC KNOWLEDGE

In responding to the reviewers' initiating actions, case doctors may accept just those terms proposed. Thus case doctors may treat consensus-building and bureaucratically focused formulations as requests to address only the specific issue or issues raised. In Extract 6, the doctor gives minimal responses to the reviewer's bureaucratically framed questions about the patient's treatment history.

In this instance, the reviewer initiates the case discussion with a bureaucratically focused opening, framing the review as a need for documentary information on the patient's history (lines 4, 11). The reviewer's telling of the history as recorded in his file also implies a possible problem or discrepancy between the doctor's recommendation for surgery and the lack of recent history on the patient (the patient was seen only once, more than a year ago, lines 5–10). In response to the reviewer's initial and subsequent questions, the doctor provides unelaborated answers. He provides "just the facts" of the case in response to requests for specific information to fill in gaps in this administrative record (lines 14, 17, 20, 23), thereby accepting the bureaucratic alignment proposed by the reviewer.

The review, however, is not a unilateral achievement: Within the opportunities and constraints provided by the reviewer's initial formulation, the doctor may resist, ignore, contest, or otherwise respond in ways that redirect the trajectory of the review. In Extract 2 (see p. 207), the doctor resists the bureaucratically focused initiation by challenging the reviewer to account for reported in-

Extract 6

```
1   R:     .hhh Um (0.3) the um- (0.1) I can
2          see that he's scheduled for a PE tube insertion
3          (an') he's two years old, (0.4) an' according
4          to our information (0.6) uh hhh it looks like
5          uh (0.2) he had uh previous tubes in ni- in April
6          of eighty nine, °.hhh° and uh (0.5) uh hhh
7          and uh hh (0.4) apparently he saw Doctor Wi- William
8          uh (Sutcliff), (0.1) for one visit h. °.hh° Uh
9          that was in uh hh April of eighty nine. hh .hh
10         an' that was the only visit there, .hh um (0.3)
11         an' I don't have any more information,=When- When
12         did you uh most recently h- see 'im uh (h)in-
13         (.) with regarding his recurrent effusion?
14  D:  -> Twenty ninth of May,
15  R:     (h)Okay, (0.3) What um and (eh)what-
16         what did you see at that time,
16         (0.2)
17  D:  -> Uh (.) bilateral middle ear effusio[n,
18  R:                                        [Mmhm. (.)
19         So serous otitis media? (.) Yeah.[.h
20  D:  ->                                  [Yes.
21  R:     And uhw- did you uh (.) did you attempt
22         to treat 'im with uh antibiotics?
23  D:  -> °No.°                                    (8401: June 11, 1990)
```

Extract 2 (Continued from Page 207)

```
26   R:    Okay. Alright.=Yeah I'm- I'm (.) glad you corrected
27         that. .hh Do you know how long she's had this
28         effusion?=
29   D:    =(Kay/Hey,) I've been seeing this young lady since .hh
30         (0.7) over three years. hh hh (.) and I put tubes
31         in, her ears, the first time in March of nineteen
32         eighty eight...                          (2222: April 22, 1991)
```

formation that conflicts with his own record on the patient.

As discussed previously (see p. 207), the reviewer initiates discussion of this case by referring to information that calls into question the proposal for surgery—the normal hearing test (lines 8–9)—and introduces a second line of questioning about the documented length of effusion (lines 11–12). The doctor responds not by addressing the last question (regarding the effusion), but by returning to the issue of the normal hearing test. By asking the reviewer when the patient's hearing tested normal (lines 13–14), the doctor, in turn, holds the reviewer responsible for this apparently problematic information, and thereby resists the progress of the review as initiated by the reviewer. The reviewer's account of the hearing test reinvokes the bureaucratic or "record-keeping" aspect of his initiating formulation, marking the information as coming from the file: "It just says here hearing test within normal limits."

At this point (again, see p. 207) the doctor interrupts the reviewer to counter the reviewer's claim, reporting his own (or his office's) actions (lines 19–20) and his own interpretations of the test (and subsequently of his long relationship with the patient) (lines 24–25 and lines 29–32 above). By invoking his own firsthand knowledge of the patient and her test results, the doctor resists, but does not overtly challenge, the line laid out by the reviewer.

This form of resistance may be more explicit, however. In Extract 7, the doctor works to dismiss the relevance of documentation in light of his personal knowledge of the patient's severe problems. In this instance, the reviewer initiates discussion of the case by explicitly formulating the problem as a matter of documentation.[8] He begins the next unit of his turn by referencing his understanding of a failed hearing test (lines 3–4), but is intersected by the doctor, who confirms that the patient failed the hearing test. The doctor then provides a description of the patient that is notably firsthand, even vernacular: "He's got a ton of fluid behind his ears." The issue of documentation is dismissed as irrelevant for this case, given both the patient's experience of hearing loss (lines 7–8) and the doctor's firsthand judgment: The "kid cain't hear thunder" (lines 9–11). The unmitigated assertion directly opposes the relevance of the general criteria—for this particular case. Although the reviewer subsequently reasserts several times the relevance of the criteria and the documentation several times, and although the doctor attempts to provide such documentary information, the doctor ultimately returns to his own local judgment, again asserting that the patient "just cain't hear."

In this case, the doctor works to dismiss the relevance of the formal criteria. In his judgment, the patient's condition is severe enough to warrant surgery, even though the problems have not been documented long enough to satisfy the criteria. In the face of such resistance, the reviewer reinvokes the relevance of the criteria at each turn.

The introduction of firsthand knowledge of the patient is a common practice for resisting a bureaucratic frame. This practice, however, is also used in response to collegial requests, as doctors consistently speak at length about their relationship with a patient or detail a line

[8] This is the second patient reviewed during this call. The previous case was rejected for tonsillectomy surgery because the doctor could not document the number of episodes of tonsillitis: The "again" in the reviewer's initiating formulation indexes that prior case. Also, this initiation is designed precisely as a *second* initiation, built by the reviewer to be heard and understood by reference to the previous case.

Extract 7

```
 1   D:    .hh Yeah Steven Agar.
 2   R:    Now this one again I think we may have eh least my
 3         problem is the documentation. .hh I understand he's
 4         failed a hearing test=
 5   D:    =Yeah he failed a hearing test an' he's got a ton a
 6         fluid behind his ears .hh with a (.) with a hearing lo-
 7         with a subjective decrease in hearing loss fer
 8         fer a year. hh Uh .h now that's- yer right it's not
 9         documented uh e- for [that long but this kid cain't
10   R:                         [We-
11   D:    hear thunder. He [let's see he's about uh]
12   R:                     [W'll do you know       ]when the
13         hearing test was document[ed?
14   D:                              [.hhh Uh that was done in uh
15         tch.that was done'nssshwshwshwsh hhh .hh uh I think it
16         was done in school an' then a follow up but I don't
17         know exactly when that was.                (1656: April 19, 1991)
```

of clinical reasoning. Thus doctors tend to treat these questions not as "collegial" or friendly inquiries, but as requests for accounts of their actions, knowledge, and clinical judgments. In Extract 4 (see p. 209), the doctor formulates his response to the request "Can you tell me something about this youngster?" by retracing his chronological and relational history with the patient. Except to specify the date of the doctor's most recent visit—information relevant to the criteria—the reviewer withholds talk as the doctor (re)constructs his case.

The collegial request invites the doctor to identify the most relevant or most "tellable" features of the case. The topic initiated (Schegloff 1995) is the patient, but the request, as it is formulated, does not specify which aspects of the patient should be or might be addressed. The doctor, then, is faced with a problem of description: Although he has been asked to provide "some" information about the patient, the design of the reviewer's turn has not given him any resources for narrowing the range of possibly relevant answers. In other words, the doctor must provide a description for only imperfectly known purposes, namely that his clinical recommendation regarding this case is "up for review." The description he

Extract 4 (Continued from Page 209)

```
 7   D:  -> Okay six five eighty nine is when he was referred to
 8          us by family physician for questionable hearing loss.
 9          There was a history of (.) recurrent ear infections
10          at that time. But I didn't find anything in the
11          youngster's ears at that time, tympanograms were normal
12          but mother had noticed intermittent hearing loss. Okay.
13          .hh Uh Febuary the 'leventh was when I saw (.) [
14   R:                                                    [That's
15          this year?
16   D:     This year. [(    ) for again h and we have a hearing
17   R:                [Yeah.
18   D:     test that was dated January sixteenth from the school
19          now this is the school audiogram.
20          ((8 lines omitted))
21   D:     With that much hearing loss (.) we felt we needed to git
22          this fluid out an' git the tubes in.      (8462: February 12, 1991)
```

provides addresses precisely this understanding.

The doctor begins with what he portrays as the consequences of the patient's illness: a hearing loss that dates back some time (lines 3–8, p. 209). This is perhaps the most serious potential consequence of this illness because a hearing loss of some duration may entail delays in speech acquisition and other developmental difficulties. In this way the doctor establishes both the length and the seriousness of the patient's problem. In addition, through this formulation, the doctor characterizes his own relationship with, and firsthand knowledge of, the patient: He and the patient have a significantly long recorded history. The current proposal is accounted for in terms of its position in a long-standing history of problems and contact, and the doctor's caution in arriving at the recommendation for surgery is established (lines 21–22).

Though lay ideas about the incontestability of clinical symptoms might suggest that the "facts may speak for themselves" in this situation, doctors under review do not respond in this way; instead they respond to the review as a request for an account of their clinical reasoning. Typically, such accounts are not limited to "factual" descriptions of audiometry readings or diagnostic outcomes (such as "otitis media with effusion"); instead they are constructed as persuasive accounts composed of evaluations, assessments, and predictions. These accounts emphasize the personal relationship between doctor and patient: providing "eyewitness" descriptions of the patient, detailing the visual aspects of physical examinations, and marking the extensive and lasting character of the doctor-patient relationship.

Collegial requests are rarely met with minimal or "just the facts" responses; in only one instance in the database did a doctor respond to the reviewer's collegial request with a counter-request to narrow or specify the domain of inquiry. Overwhelmingly, in response to such requests for information, doctors invoke local knowledge to account for the legitimacy of their clinical judgment.

When the relevance of a case's "facts" are in dispute, the invocation of local knowledge is one practice for attempting to supersede the relevance of the criteria *for that particular case*. The problem for the reviewer, of course, is that the criteria must be applied to any (and every) particular case. In instances such as these, when the details of the specific case are presented as fundamentally at odds with the general criteria, appeals to shared collegial understandings are common for both reviewer and doctor. In cases that are ultimately denied, however, the reviewer may distance himself or herself from that decision by invoking, at the end, the relevance of the criteria.

ANNOUNCING DECISIONS: BALANCING COLLEGIAL AND BUREAUCRATIC PRESSURES

In announcing a decision, the reviewer makes an explicit judgment about the legitimacy of the doctor's recommendation for surgery, at least in relation to the criteria. Decisions are consequential: The outcome very likely will determine the treatment the patient receives. Like forms of agreement and disagreement in ordinary conversation (Pomerantz 1984a; Sacks 1987), approvals and denials are accomplished differentially; each is designed to manage the particular relevancies that the decision invokes.

Typically, announcements of approvals are formulated straightforwardly and simply; accounts of or justifications for the decision, if offered at all, focus on aspects of the doctor's prior answers that are directly relevant to the criteria. In the decision phase of Extract 2 (see line 40, p. 215), for instance, the reviewer announces his decision and refers to the new information (regarding the length of the effusion) as the basis for his announcement.

The doctor responds to the reviewer's question for the length of effusion with an extended telling of his contact with the patient, emphasizing the lasting character of his relationship with her (lines 29–36) and concluding with a summation of the elapsed time. The reviewer then announces his decision to recommend the case for approval (line 40). In keeping with the bureaucratically focused initiation, in which the reviewer characterized the problem as a lack of information on his part, his decision revives information as the relevant issue and announces that the problem has been solved:

Extract 2 (Continued from Page 212)

```
29   D:    =(Kay/Hey), I've been seeing this young lady since .hh
30         (0.7) over three years. hh hh (.) and I put tubes
31         in, her ears, the first time in March of nineteen
32         eighty eight hh .hh (0.2) um (0.9) an' then they
33         uh hh (1.0) tubes came out, hh (0.4) I did a hh
34         repeat on th' r(hhh .hh)- th' right ear in September
35         of ninety, (0.7) .h and then thuh hh (.) an' that ear
36         is fine, but the left ear has developed fluid again.
37         (0.2) So let's see. (0.2) I've been following the
38         left ear hh (0.2) since January with fluid in
39         it.=It's had persistent fluid.
40   R: -> Okay I'm gonna go ahead and recommend it.=I .I
41         didn't have that informat[ion.=I really thank you for
42   D:                             [°Okay.°
43   R:    your time.                                  (2222: April 22, 1991)
```

The doctor has provided the information that the reviewer lacked. The call then is immediately closed.

Denying a case, on the other hand, is an interactionally delicate action, understandable as a disagreement with the doctor's clinical judgment. Like forms of disagreement in ordinary conversation (Heritage 1984, chap. 8; Pomerantz 1984a; Sacks 1987), denials are designed and executed in characteristic ways. Mitigating elements such as accounts, suggestions for alternative treatments, explicit alignment with the doctor, and distancing from the bureaucratic decision-makers are frequently used to construct or delay negative decisions. It is precisely in the design and receipt of these mitigating elements, with each doctor enlisting the other as a colleague, that the conflicting pressures are manifested again, even as the precedence of the bureaucratic requirements is acknowledged.

In Extract 8, the reviewer uses an array of mitigating elements to delay announcement of the denial and to give the doctor opportunities to defer the recommendation for surgery. At the same time, the reviewer manages his position as both bureaucratic representative and fellow specialist. The call opens with a bureaucratically focused initiation;[9] then, through a sequence of questions and answers, the reviewer establishes that the patient has not been under another doctor's care (and has been seen only once by this doctor, four weeks before the call). The reviewer then begins his cautious rejection of the case, which culminates in a proposal for alternative treatment that projects the ultimate rejection of the doctor's recommendation (lines 15–16).

The reviewer leads up to his rejection of the case, first identifying the problem with the case and then proposing an alternative treatment. This denial, then, is delivered in a way that de-emphasizes and even leaves ambiguous the reviewer's personal judgment. In line 3, the reviewer presents the problem as originating with the deliberations of the "expert panel"; thus the problem has been imposed on both parties by the experts who devised the criteria. The reviewer then aligns himself with the doctor, acknowledging that the doctor acted properly (lines 5–6).

The reviewer next poses a question (lines 15–16) that shifts the standards for approving the case and enlists the opinion of the doctor as fellow practitioner—"Would you see any problem with following him to see I mean if it did clear up?"—and invites the doctor to accept an alternative course of action—waiting to see if the problem clears up on its own rather than inserting tubes. The question is constructed to prefer a "no" answer (Sacks 1987) and tacitly acknowledges the doctor's status as a fellow practitioner. Identification of the problem, invocation of the expert panel, and the suggestion of an alternative treatment can be heard by the doc-

[9] Because of space limitations, I provide only a rough gloss of the portions of the call not included in the extract.

Extract 8

```
 1   R:    I see. 'Cause that- (.) that's really where the- (.)
 2         where the problem has come up on the case,=They-
 3       -> (0.2) an expert panel was (.) assembled
 4         and uh (.) they felt that uh in- (.) in children
 5       -> especially this age you should have uh- you should
 6       -> treat them as you've done, with antibiotics but
 7         wait t' see i[f th- the fluid will clear up for
 8   D:                 [Oh I-
 9   R:    three months uh 'cause uh many of 'em will,
10       -> Now if- if I could just verify that (0.2) he'd been
11         treated previously you know it'll be around two
12         months uh-
13   D:    Yeah.
14   R:    Uh almost two months uh with the thing but (.)
15       -> uh would you see any problem with following 'im to-
16       -> to see <uh I mean if it did clear up u[h?>
17   D:                                            [Well, (.)
18         I have no problem with following 'im except uh I
19         wouldn't bet the rent that it will,=What u[sually
20   R:                                              [Yeah.
21   D:    happens is the pediatrician puts 'em on (.) uh
22         antibiotics for three months [(which has) no effect in
23   R:                                 [Oh I know,
24   D:    on clearing the ea[r ( ) then they gotta give up and
25   R:                      [Right, Right.
26   D:    turn 'em over to the ear nose and throat man who now
27         has to remove stuff that's the consistency of glue,...
                                                (5888: December 17, 1990)
```

tor as foreshadowing rejection. Although he nominally backs away from the recommendation in accepting that it would do no harm to follow the patient longer, he qualifies this acceptance with a prediction that it won't work and with a narrative account based on his clinical experience of what "usually" happens in such cases. Cast in terms of the doctor's firsthand experience, this description revives the legitimacy of his initial recommendation for surgery.

The doctor never accepts the reviewer's decision outright, but by the end of the call, he agrees to tell the patient that there is an appeal available. His original recommendation is intact, at least formally, because of the actions of both doctors.

Overwhelmingly, reviewers design negative decisions in ways that attempt to minimize the differences between doctor and reviewer. They create opportunities for the doctor to assume a stance toward the decision that does not overtly threaten the legitimacy of the initial recommendation. At the same time, reviewers may invoke the criteria as support or motivation for the decision. In doing so, they reveal the bind in which they are caught: On one hand, according to the norms of the profession, a doctor's clinical judgment is beyond question; on the other, the reviewer has been hired to maintain the bureaucratic standards of the utilization review firm. In managing these conflicting pressures, the reviewer constructs a decision that invokes both concerns: Formulations such as "The problem is in documenting the visits" appeal directly to the criteria and invoke as the final arbiter the bureaucratic regimen—not the reviewer, who, after all, is a fellow doctor. Similarly, inviting the doctor's medical judgment—as in "would you see any problem in following him"—explicitly invokes the doctor as a colleague and thus attempts to preserve an environment of autonomy and collegiality, even as the denial of the case compromises it.

Extract 4 (Continued from Page 213)

```
21  D:  ...With that much hearing loss (.) we felt we needed to
22      git this fluid out and git the tubes in.
23  R:  Okay. Um (.) as a general rule uh has he
24      had any treatment of antibiotics or any kind of treatment
25      like that?
26  D:  Why would you treat chronic serous ot[itis (       )
27  R:                                        [Well sometimes
28      they res- be surprised they do respond.
29  D:  HAH! Not with a thirty-five decibel [(hearing loss)=
30  R:                                      [Num well
31  D:  =I'm afraid. I'm not- I'm gonna be responsible
32      for a permanent hearing loss when we've got that much
33      air bone gap.... ((8 lines omitted)) An' there's
34      no way that we're jus' gonna give 'im antibiotics and
35      then have 'im be [doin' this the rest of his life.
36  R:                   [.hh  W-  w-  w- w-  w- well- would it
37      be po:ssible to to uh give him some antibiotics an'perhaps
38      [postpone the surgery for ABOUT TWO OR THREE WEEKS?
39  D:  [(No.) I'm not going to go along with you at all
40      doctor....                                  (8462: February 12, 1991)
```

The threat posed by that denial, however, may be minimized more or less easily. Though the reviewer may include mitigating elements such as enlisting the doctor's clinical opinion and invoking bureaucratic relevancies, those elements may fail to reduce the impact of the negative decision, especially when the initiating question did not establish a bureaucratic context for the review. In Extract 4, the reviewer's initial utterance, implying rejection, is met with resistance and ultimately with open disagreement.

The doctor resists the reviewer's repeated efforts to suggest alternative treatment. In contrast to the previous example, however, the reviewer does not overtly align with the doctor in appreciating his efforts to treat the patient; nor does the reviewer explicitly invoke the criteria as a means of distancing himself from the decision. Instead he moves directly to a question that addresses the criteria but also can be heard as a treatment suggestion (lines 23–25). Thus although the reviewer begins by implicitly referring to generalized guidelines that may contradict or disagree with the doctor's decision to "git the tubes in" (line 23), he restarts his utterance with a question that probes the doctor's clinical judgment in selecting a treatment course: "Has he had any treatment of antibiotics or any kind of treatment like that?"

The doctor responds to the question as a treatment suggestion and challenges its content (line 26); the reviewer's informing (lines 27–28) reflects directly on the doctor's knowledge of such patients and his competence in treating them. After the doctor's outright rejection of antibiotics (lines 33–35), the reviewer proposes an alternative strategy (lines 36–38). As in the previous example, he enlists the doctor's clinical opinion and offers an alternative standard that preserves the legitimacy of the original recommendation: "Would it be possible to give him some antibiotics and perhaps postpone the surgery for about two or three weeks?" Unlike the reviewer in the previous example, however, this reviewer neither precedes this treatment alternative with reference to the bureaucratic criteria nor distances himself in some other way; the doctor treats his proposal as a professional recommendation and rejects it as such (lines 39–40).

The reviewer's repeated efforts fail to bring the doctor into alignment over the decision; at each successive step, the doctor treats the reviewer's suggestions as implicating—and directly challenging—his clinical judgment and competence as a professional. The call continues for another three minutes, during which the doctor refuses to accept the "suggestion" that the patient be

treated with a course of antibiotics. Finally, rejecting outright the reviewer's position—and the review process—with "I really can't go along with that at all. I really can't," the doctor hangs up while the reviewer is in mid-utterance.

EVALUATION AND DISCUSSION

In the very formulations used to initiate case discussions, describe patients, and announce decisions, both the case doctor and the reviewer show their orientations to the conflicting pressures of collegial norms and bureaucratic requirements. As I have argued, the initiating actions through which reviewers begin a discussion of a patient's history are consequential because they set a trajectory for the ensuing review; subsequent responses by the doctor may introduce alternative relevancies; and decisions frequently are announced so as to preserve or maximize bureaucratic primacy. Although many contingencies arise during a particular interaction, the opening questions (and the relevancies they introduce) remain important. The statistical relationship between the opening formulations used and the eventual case outcomes suggests further possible elaborations of the relationship between the opening formulation and the subsequent environment of the review.

Table 1 suggests a significant relationship between the type of initiating formulation and the case outcome: Controlling for the reviewer's specialty, collegial initiating formulations increase by a factor of 3.3 the likelihood that a case will be approved, in comparison with bureaucratically focused initiations.[10] This finding has several alternative explanations.

On one hand, the finding may reflect *external pressures on the reviewers* as they choose between formulations. In other words, reviewers' choices of formulations may be based on or shaped by the participants' social-structural characteristics—their relative statuses, their organizational positions, or other structural constraints. Thus it may be that reviewers base their choice of initiating formulations on an understanding of their position relative to the doctors they are reviewing.

Table 1. Coefficients from the Logistic Regression of Initiating Question Format on Review Outcome

Variable	Coefficient	Odds-Ratio
Format of Initiating Question[a]		
Consensus-building	.345 (.441)	1.41
Collegial	1.198** (.448)	3.31
Reviewer's Specialty[b]		
Pediatrician	.188 (.841)	1.21
Otolaryngologist	−.529 (.793)	.59
Constant	.641 (.825)	1.90
Log-likelihood ratio	−39.457	
Number of observations	68	

Note: Numbers in parentheses are standard errors.

[a] Omitted variable is "bureaucratically focused initiation."

[b] Omitted variable is "other."

** $p < .01$

Indeed, the parties occasionally orient to factors such as professional status during some reviews. For instance, reviewers may overtly align with the doctor under review, invoking comparable professional status as a warrant for understanding the intricacies of a case, as in: "I'm an otolaryngologist too, so I can understand when you tell me." Doctors, too, may orient to relative status as a relevant feature of the interaction, particularly when rejection of the case is implied. One case doctor, hearing imminent rejection of his case, held the reviewer accountable for his background, training, and licensing status: "What is your name? How is that spelled? An' you're calling from where? Are you licensed in Minnesota? And what is your training?"

The review process, however, is designed to neutralize factors such as the interactants'

[10] For comparison here, I focus on the two most explicit "extremes": bureaucratically focused and collegial. I corrected for a clustering effect by individual reviewer, using the Huber correction. See *Stata Manual* (1995, vol. 2:456–65) for a description of this correction.

relative statuses or organizational positions. Unless it is made explicit in the review itself (and usually it is not), each participant is completely unaware of the other's status, location, organizational standing, and other information. Reviewers know only the name, specialty, and telephone number of the doctors they review; in most cases, the two doctors have never spoken before and live in different states. When status *is* made relevant during the review, it is mobilized (equally by both participants) to perform specific actions in specific sequential contexts. Thus a reviewer may use professional status (as a fellow otolaryngologist) to align overtly with a doctor when delivering a negative decision or displaying collegial solidarity; a doctor may mobilize status in an environment implying rejection as a way of challenging a negative decision or blocking the progress of the review. The main point here is that social status usually is not invoked at all and thus remains unknown to both participants. If it is invoked, social status (or, more specifically, professional status) is used to accomplish specific actions at certain points during a review.

A second possible understanding of this finding is that it reflects a *direct intentional relationship between initiating formulation and the reviewer's expectations* about the outcome of the review. For example, it is possible that each reviewer, after examining the paper trail from the first-level review and before placing the call to the doctor, has a sense of the case's merits in relation to the criteria and thus formulates a first question in light of that sense. Thus it is possible that reviewers who choose the bureaucratically focused format are "predisposed" toward denials. The bureaucratic frame built into this format could therefore be understood as a strategy, selected by the reviewer to minimize the interactional impact of the denial that he or she knows is probable and/or imminent. The bureaucratically focused format, then, may project the sense that the case as a whole is problematic, and that the specific questions about patient history and documentation are the evidence of that problem.

In contrast, reviewers who choose the collegial format may be "predisposed" toward approvals. Thus the collegial format may reflect the reviewer's sense that the case is in "good shape," the collegial relationship is not in jeopardy, and the interactional "protection" offered by the bureaucratic frame is not necessary.

A third alternative explanation is that this finding indicates *the impact of the initiating formulation on the subsequent interactional environment*. As demonstrated by previous conversation analytic research (Heritage 1984; Pomerantz 1984a; Sacks 1987), the structure of prior utterances constitutes the immediate context for subsequent utterances, where that context both provides opportunities for and places constraints on what will be hearable as an "answer" or a "response." The bureaucratically focused format, by raising specific questions about aspects of the patient's history, places certain constraints on the doctor in answering: Generally, in such situations, doctors are limited to providing the information requested or accounting for its absence. The bureaucratic frame, again, allows the reviewer to avoid directly implicating the doctor's clinical judgment; the subsequent formulation of the question(s) directs the inquiry to specific issues. In the event that the doctor's responses do not satisfy the criteria and the case is denied, the bureaucratic frame may be reinvoked and the negative decision may be mitigated somewhat.

The collegial format, on the other hand, does not initially place such topical constraints on the doctor. The result is a sequential environment in which the doctor may "make a case for surgery." In constructing their responses to collegial requests for information about the patient, doctors typically describe histories that establish the nature of the patient's problems and the character of the doctor's relationship with the patient; thereby they warrant or present a line of reasoning that supports the recommendation for surgery. Should the details of the case fail to meet the criteria, the reviewer must raise questions about the doctor's professional competence, as displayed through the extended account. Without a bureaucratic frame in place, the reviewer must do additional interactional "work" to deny the case or risk open disagreement, as was seen in Extract 4. It may be precisely this potential for conflict that militates against denials when the collegial format is used.

Much work still must be done to expose and explain the various interactional procedures underlying the relationship between the participants' talk and the final outcome of a case; I do not mean to suggest that the outcome of any case is predetermined by a particular initiating formulation. Rather, as I have shown here, the boundaries between collegial and bureaucratic authority are not fixed or static. Each participant may mobilize aspects of either type of authority to manage particular interactional issues: To introduce the business of the call, to resist the progress of the review, to issue an unfavorable decision. In doing so, the participants reveal aspects of their institutional relationships and professional understandings.

CONCLUSIONS

In a different context, Weber (1947) argued, "Bureaucratic authority in the modern world has . . . everywhere led to a weakening of the role of collegiality in effective control" (p. 402). Ironically, in the medical peer review, the collegial relationship may be protected most effectively by recasting the review as primarily a bureaucratic formality.

Scott (1982) proposed that peer review gains its legitimacy by "harnessing the collegial norms of the profession" (p. 220). As I show in this paper, however, the collegial relationship is complex. Initial access to the interaction is based largely on the reviewer's institutional credentials, and the reviewer's authority is surely augmented by his or her professional status as a fellow physician. Aligning along purely collegial lines, however, can prove problematic; instead, reviewers consistently mobilize aspects of the bureaucratic requirements or relationship so as to minimize the threat of interactional conflict. Thus the reviewer frequently acts not as a fellow doctor but as a bureaucrat for whom documentary evidence, not professional judgment, is the overriding consideration. Similarly, arguments appealing to shared collegial understandings or values, such as the primacy of clinical expertise and firsthand knowledge, are frequently recast by the reviewer in terms of the criteria. Relying on or appealing to the collegial relationship alone, as in Extract 4, may increase the likelihood that the doctor's judgment or competence (as well as the reviewer's) will be confronted directly.

The implications of this paper extend beyond the peer review and may be generalizable to other institutional and interactional contexts containing the potential for conflict. Some organizational studies suggest that bureaucratic arrangements do not always minimize conflict within organizations (e.g., see Kolb and Bartunek 1992; Morrill 1995). Studies of *interaction* in other settings, however, suggest that participants use various forms of mitigation, including bureaucratic framing, to deflect or minimize the potential for conflict. For instance, in interactions between school officials and the parents of possibly truant schoolchildren, the school official may invoke an institutional frame to avoid directly accusing the child of truancy (Heritage 1997). Similarly, broadcast news interviews often invoke absent third parties (such as the expert panel in Extract 8) to avoid assuming a positional stance (Clayman 1992); by citing an authoritative source, interactants in ordinary conversation can mitigate sensitive actions (Pomerantz 1984b). Although we do not yet know precisely how bureaucratic framing achieves its mitigating effect, it apparently operates as one type of resource for the interactional maintenance of social solidarity (Heritage 1984).

The implications of this paper also extend more broadly to studies of the medical profession and the doctor-patient relationship. Although the form and motivation may vary greatly across situations, constraints on physicians' traditional autonomy are increasingly common. From ethical guidelines issued for the treatment of critically ill patients (Anspach 1993; Zussman 1992) to technologically advanced practices introduced by specialists to rural hospitals (Good 1995), the profession must increasingly contend with the imposition of "outside" influences. The analytic framework employed here is one method for exposing and specifying the effects of such influences.

The findings of this study also have implications for a fuller understanding of the doctor-patient relationship. As increasing numbers of patients are enrolled in managed care programs that employ some form of utiliza-

tion review, and as national organizations such as the Agency for Health Care Policy and Research recommend and promote treatment guidelines, the doctor-patient relationship will surely reflect the impact of these pressures. Anecdotal evidence suggests that some insurance considerations already may be incorporated into the treatment recommendation phase of the doctor-patient consultation; additional research may reveal the extent of their relevance to the interaction between doctors and patients. Furthermore, these findings are relevant to the current debates on the efficacy of standardized treatment criteria and the resulting quality of care offered to patients; perhaps its major contribution is that it shows the importance of the participants' talk to the shape, progress, and outcome of the review. For instance, Kleinman et al. (1997) suggest that reviewers frequently approve cases for surgery even when the criteria recommend against it. In this paper I offer insights into some of the interactional factors that may influence such decisions.

Finally, in this paper I specify empirically some of the practices by which theoretical concepts such as collegiality and bureaucracy are realized. The argument that collegial authority has been weakened by the advent of external criteria-based reviews ultimately oversimplifies the relationship in practice. Without closely examining the details of the talk in peer reviews, we would lose the particular practices and orientations described here—and with the particulars we would also lose the determinate social forms through which the profession and the bureaucracy are constituted.

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Appendix A. Transcript Notation: Symbols Denoting Characteristics of Speech Delivery

Notation	Definition
`R: When was she seen?`	*Underlined items* were markedly stressed.
`R: Whe::n was she see:n?`	*Colon(s)* indicate the prior sound was prolonged.
`R: WHEN WAS she seen?`	*Capital letters* indicate increased volume.
`R: When wa- was she seen?`	A *hyphen* denotes a glottal stop or "cut-off" of sound.
`R: .hh When was h she seen?`	*Strings of "h"* mark audible breathing. The longer the string, the longer the breath. A period preceding denotes in-breath; no period denotes out-breath.
`R: When (1.0) was she seen?`	*Numbers in parentheses* denote elapsed silence in tenths of seconds; a period (.) denotes a micropause of less than 0.2 seconds.
`R: When was she seen?=` `D: =Yesterday.`	*Equal signs* indicate no intervening silence between speakers.
`R: When [was she seen?` `D: [Yesterday.`	*Brackets* mark the onset and termination of overlapping talk.
`R: When ( ) seen?`	*Open parentheses* indicate transcriber's uncertainty.
`R: When (was she) seen?`	*Words in parentheses* indicate the best possible hearing of what was said; indicates transcriber's uncertainty.
`R: °When was she seen?°`	*Degree symbols* (°) indicate a lower volume.
`R: When >was she< seen?`	*Angle brackets* indicate that the marked speech was spoken at a faster-than-normal pace.
`R: -> Whe::n was she see:n?`	*Arrows* indicate phenomena of interest.

Note: The transcripts in this paper have been simplified.

Source: Atkinson and Heritage (1984).

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