



A technical analysis of scaling in rehabilitation team talk

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Abstract

Based on an analysis of audiovisual data from multidisciplinary rehabilitation team meetings in Japan, this paper investigates how Japanese rehabilitation team members collaboratively negotiate decisions about dietary prescriptions when treating stroke patients suffering from dysphagia (difficulty swallowing). Dysphagia can be scaled by the level of patients' swallowing capacity; the lower the level, the more elaborate food modification is required. The paper first conducts componential analysis to uncover semantic relations among a set of dysphagia diets. Next, the paper draws on occasioned semantics to systematically illustrate how such relations are realized in actual interactive talk. Analysis shows that members utilize the pre-existing semantic structures of dysphagia diets as the basis for achieving various interactional activities, such as categorizing types of food, achieving rhetorical effects, and evaluating the level of dysphagia. Moreover, analysis reveals that the use of scaling diagrams is helpful in illustrating scalar relations co-constructed in actual conversation and understanding the mechanism of regrading (up/downgrading) phenomena. The paper integrates ethnographic information regarding the use of dysphagia diets into the analysis of formulation practices in decision-making activities. In so doing, the paper explores the interplay between a culturally shared, scaled semantic system and the emergent structure of meaning in medical team talk.

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1. Introduction

Conversation analysis (CA) has recognized up/downgrading (hereafter “regrading”) phenomena in sequences of verbal interactions. These phenomena are recurrently observed in assessments (e.g., [Goodwin and Goodwin, 1987](#); [Pomerantz, 1984](#)), epistemics (e.g., [Heritage and Raymond, 2005](#); [Raymond and Heritage, 2006](#); [Stivers et al., 2011](#)), and extreme case formulations (e.g., [Edwards, 2000](#); [Pomerantz, 1986](#); [Sidnell, 2004](#)). These studies have demonstrated in detail how participants in actual interactions utilize various resources, such as a set of adjective terms and intensifiers ([Pomerantz, 1984](#)), extreme expressions ([Edwards, 2000](#); [Pomerantz, 1986](#); [Sidnell, 2004](#)), and prosody (e.g., [Couper-Kuhlen, 2014](#); [Plug, 2014](#)), while engaging in conversational activities of regrading. Moreover, they have shown that regrading takes place in particular sequential environments, especially affiliative and oppositional sequences. However, they have mainly treated these phenomena in an ad-hoc manner, lacking a systematic methodology to deal with conversational meaning and rhetoric ([Bilmes, 2011, 2015](#); [Deppermann, 2011](#)). Building on occasioned semantics (OS) studies on scaling in verbal interaction ([Bilmes, 2010](#); [Prior, 2016](#)), this paper systematically illustrates how Japanese

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rehabilitation team members participating in multidisciplinary team meetings utilize a semantic setup of dysphagia diets (diets for patients suffering swallowing difficulties) as the basis for dealing with a range of professional activities in actual interactive contexts. Specifically, this paper focuses on three scaling phenomena in decision-making sequences: (1) categorization of Japanese food; (2) upgrading practices in oppositional sequences; and (3) contingent interactions between two scalar relations co-constructed in situated talk. By carefully attending to the interplay between known semantic and cultural systems and the emergent structure of medical team talk, this paper utilizes an inclusive, systematic methodology to advance our understanding of the organization of meaning and human actions. In so doing, the paper contributes to ethnomethodology (EM), CA, and OS by promoting the usefulness of understanding semantic and cultural backgrounds for the systematic analysis of meaning structures in human conduct and interaction. Moreover, the empirical analysis in this paper will be useful for healthcare providers, given the fact that there is no single convention for describing food texture modification, and thus, more research is needed in this area to understand what procedures are being used (see [Steele et al., 2015](#)).¹

This paper is organized as follows. First, I provide a literature review of relevant research on medical category criteria and healthcare team interaction in medical EM and CA studies. I then describe the primary characteristics of OS. Then, following an explanation of the data and methods, I conduct componential analysis ([Tyler, 1969](#)) to lay out semantic arrangements among a set of dysphagia diets. Finally, I draw on OS ([Bilmes, 2011, 2015](#)) to systematically examine the realization of semantic components in audiovisual recordings of medical team interactions.

2. Medical decision-making in professional team interaction

The main objective of this paper is to investigate how medical practitioners draw on their shared clinical methods and competences to co-constitute professional culture in the emergent course of practices ([Goodwin, 1994](#)). Thus, the paper shares interests with early EM studies on professional medical practices, including the army doctor's labeling practices ([Garfinkel, 2006\[1948\]](#)), clinical procedures used by doctors to comprehend medical records ([Garfinkel and Bittner, 1967](#)), and medical criteria used by hospital staff to classify the status of fetuses ([Sudnow, 1967:109–112](#)).

More specifically, this paper examines how Japanese rehabilitation team members use semantic scales of dysphagia diets to negotiate decisions about dietary prescriptions in actual situations of talk, particularly through the interactive and categorical dimensions of multidisciplinary teamwork ([Housley, 2003; Izumi, 2014](#)). My analysis, located at the junction of institutional ethnography and CA, is primarily informed by medical CA research.

Medical CA, a subfield of CA which began in the late 1970s, has grown into a vast literature on clinical interactions over the last 40 years ([Gill and Roberts, 2014](#)). This corpus of studies includes doctor-patient interactions, encounters beyond the doctor's office (e.g., physical therapy sessions), interactions between medical professionals, and medical technologies in interaction ([Gill and Roberts, 2014; Pilnick et al., 2010](#)). Apart from workplace studies that have described how clinical team members, such as surgeons, nurses, and anesthetists, work together to process complex ongoing medical activities (e.g., [Hindmarsh and Pilnick, 2002, 2007; Koschmann et al., 2007; Mondada, 2007, 2011; Svensson et al., 2009](#)), the work most relevant to the present study concerns medical team meetings organized by healthcare practitioners (e.g., [Arminen and Perälä, 2002; Caronia et al., 2017; Ikeya and Okada, 2007; Izumi, 2014, 2017; Turowetz, 2015; Turowetz and Maynard, 2015](#)), especially diagnostic decision-making in medical teams. [Turowetz \(2015\)](#), for example, shows how clinical team members from various disciplines, such as developmental pediatrics and speech pathology, work together to identify whether children have autism. He illustrates the ways in which team members assemble test instruments to evaluate children's cognitive skills, and use citation practices, such as animating children's symptoms through direct reported speech, to build a case for diagnosis. Such a practice is based on a particular team member's specialized professional knowledge and access to a specific patient's state ([Angell and Bolden, 2016](#)). The production and distribution of knowledge among different categories of specialists is also relevant to the data I examine.

Displays of knowledge in multidisciplinary teams are tied to the role specific category incumbency ([Housley, 2003](#)). [Izumi \(2014\)](#), for example, draws on CA and membership categorization analysis (MCA) to examine how Japanese rehabilitation team members participating at multidisciplinary team meetings respond to doctors' questions regarding patients' daily-living functions coded in the medical chart. The chart contains a series of functional assessment items, such as "eating" and "dressing," which are category bound to a particular specialist's work and responsibility. He shows that such a division of labor is made relevant through member orientation to doctors' questions and can be locally negotiated in particular occasions.

¹ An explication of how the institution works at the micro-interactive level and thus, illumination of applied potentials, is one of the major strands in applied CA ([Antaki, 2011](#)).

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