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Playback: An Investigation of the Discursive Implications and the Pragmatic Functions of Repetition in Traditional Chinese Medical Consultations

Abstract

The current study examined a role-related difference in the use of playback (one form of repetition) in medical discourse. We adopted a language and social psychology approach and invoked CAT to explore this discourse. Thirty doctor/older-adult dyads were recorded and transcribed verbatim. Findings suggested that the deployment of repetition is a strategy used by the addresser to either complement or converge to the other interlocutor, in order to ensure that the medical instrumental task is efficiently accomplished and interpersonal rapport is established. Our results show that discourse management is the dominant strategy used by speakers when playing back the other's utterances. Our analysis also demonstrates that CAT strategies work interdependently. We conclude that CAT is a valuable framework to elucidate the dynamics of, and the social psychological processes underlying, the practice of repetition in medical interviews.

Key words: playback, communication accommodation, traditional Chinese medicine

Repetition is omnipresent in almost any type of interactional discourse. Tannen (2007) noted that repetition is a rich resource for language production, comprehension, connection, and interaction. For example, it can be used as a resource for teaching and learning in classroom interactions (Roh & Lee, 2018), as a supportive and/or remedial device in business transactions such as a service encounter (Blackledge & Creese, 2018), or as an indicator of politeness and courtesy in ritual greetings between friends and colleagues. The pervasiveness of repetition is particularly observed in medical discourse which can be fairly considered as a genre of repetition: the very acts of visiting the same doctor, the constant retelling of the story (e.g. patient experience), all of these encourage repetitive talk.

Despite the centrality of repetition in medical discourse, it has received insufficient attention among linguists and health professionals. Many recent studies seemed to be interested in repetition as a symptom or challenge due to health-related complications as for example, in the speech of brain-damaged patients (Boo & Rose, 2011; Nozari et al., 2010). Yet people are far less informed about the role of repetition as a universal feature of language in everyday medical discourse. Thus we argue it deserves closer investigation. Ferrara (1994) is the exception as she did examine repetition in therapeutic discourse. But her study only provides a broad taxonomy of repetition without any detailed discussion of its roles, functions, and sequences in contexts. To fill this gap, the current paper discusses the dynamics of playback – the repetition of the name of the requested item in a service encounter (Merritt, 1977, to be discussed

in detail later). See one example below.

P: Doctor, my urine is foamy.

D: Foamy.

P: Yes, foamy.

This short extract was selected from one of our observations of real-life medical interactions and raises an important yet underestimated issue to be explored in this paper. From an interactional perspective, we studied how playback serves the dual functions of medical task completion and rapport building. The paper focuses on older adults, because with the expanding aging population, they represent a large proportion of the patient population.

This study contributes to the empirical investigation of repetition by analyzing authentic doctor/older-adult talk, which has both theoretical and practical implications for the understanding of language and social interaction with respect to repetition. Although researchers such as Tannen have presented a thoughtful analysis of various functions of repetition, including its interpersonal aspect (e.g. Tannen, 2007), one area which is underexplored is the socio-psychological underpinnings that explain participants' behaviors in situated interactions. We address this gap in the context of medical settings, and invoke Communication Accommodation Theory (CAT: Giles, 2016). While much of the recent CAT research has been experimental and questionnaire-based (Gallois, Weatherall, & Giles, 2016), we demonstrate the robustness of CAT in exploring the richness of talk (see also Gallois & Giles, 2015; Gallois, Watson, & Giles, 2018). We also contribute to discourse analytic research by

demonstrating how repetition in languages other than English also displays a systematicity as does English (see also Hsieh, 2009).

Traditional Chinese Medicine in China

The healthcare system in Mainland China is composed of two medical practices: western medicine (WM) and traditional Chinese medicine (TCM). While WM is studied from a biomedical perspective in western cultures, TCM is deeply rooted in Chinese culture. TCM is based on a pathology, etiology, and philosophy that considers the human body as a holistic unity so that any dysfunction in one part of the body can influence and further affect other parts (for more discussions, see Xu & Yang, 2009). This philosophy is also built into the construction of medical prescriptions. Each TCM prescription is unique (e.g. the type of the herbs and their dosage). In China, TCM is well-established in medical institutions. It has its own specialized clinics that provide only TCM services (e.g., acupuncture). Given its importance, knowledge of TCM, including its principles of practice, is built into the syllabus of WM in the majority of Chinese medical institutions (Huang, 1999). ~~Therefore, alongside other contributions, the present investigation of repetition (playback) extends understanding of TCM health communication.~~

The Playback

Merritt (1977) coined the term playback based on naturalistic observations of speech in service encounters, as a form of immediate repetition. The functions of these are (i) to correct any possible error in the server's understanding and interpretation of the customer's request or order, and (ii) to confirm the server's willingness to satisfy the

customer's needs. Merritt observed two types of playback: the queryback and the affirmative playback. The difference between these two forms resides in whether the addresser requires a response. The queryback is used for an answer (e.g., a request for clarification or confirmation), whereas no response is required for the affirmative playback. Adapting Merritt's (1977) conceptualization of the playback, we define playback as a form of immediate repetition built on a prior statement made by the interlocutor. It could either be (i) a query with question intonation inviting patient repair or extension (e.g. Patient (P): I had a cough. Doctor (D): A cough?), or (ii) a plain statement indicating attentiveness and information receipt (Johnstone, 2018; Schegloff, 1997) (e.g. D: Take a blood test first. P: A blood test.).

Theoretical Framework

Communication accommodation theory is a general theory of communication that explains "how individuals use language and strategic communication behaviors to negotiate social interactions between themselves and others" (Hewett, Watson, & Gallois, 2015). It has been widely applied to research in various institutional contexts (see Jones, 2019; Watson & Soliz, 2019, for recent reviews) including medical settings. CAT proposes that individuals are motivated to be accommodative or non-accommodative with their speech partners. The usefulness of CAT as a model to explain the dynamics in different hospital settings is well-documented in the literature (e.g. Chevalier et al., 2017; Gallois et al., 2015; Watson, Jones, & Hewett, 2016).

Street (1991) discussed two types of accommodation in medical consultations: convergence and complementarity. Convergence is a strategy where conversationalists

adapt to each other's communication behaviors at a wide range of "linguistic-prosodic-nonverbal" levels (Giles, Coupland, & Coupland, 1991: 7). Convergent interactions feature mutual alignment and highlight intergroup and interpersonal similarities. For example, both participants may actively engage in communication by sharing information, allowing each other conversational turns, and using terms that each can understand. On the other hand, complementary interactions typically refer to communication behaviors that are not convergent but normative. For example, in an interview situation, the interviewer may speak slowly to question or check answers and for only short durations. The interviewee, with less power and wishing to appear competent, may speak more quickly and for longer turn durations (Street, 1991). In this instance, the intergroup salience of each speaker is evident (for a recent review, see Rakić & Maass, 2019).

It is beyond the scope of this paper to present the history and the numerous propositions of CAT as it has been developed and refined over the past decades. The theory has expanded from a theory on speech adjustments to a more psychosocial theory, including varying discourse strategies and other nonverbal activities (see Giles, 2016; Harwood et al., 2019; Morgan et al. 2017, for more recent discussions). Generally, CAT posits that individuals tend to use an accommodative stance in a given interaction to evoke approval. CAT presents five communication strategies: approximation, interpretability, discourse management, emotional expression and relation management, and interpersonal control (Giles, 2016). *Approximation* refers to

productive communication behaviors of individuals that reflect adjusting toward (convergence) or away from (divergence) their speech partners. Approximation concerns the behaviors of matching the speech production (e.g., accent, pitch, rate and volume) of each speaker. *Interpretability* refers to how well an individual's communication behaviors attune to their conversational partner's communication competence in order to be understood. In the medical setting appropriate interpretability can refer to the doctor's avoidance of technical terms that may not be understood by the patient. Playback featuring the doctor's interpretability includes, for instance, repeating exactly what is said by the patient (e.g., when the patient told the doctor that she had a heart attack, the doctor could say 'yes, a heart attack' rather than 'yes, a myocardial infarction'). It reflects the speaker's awareness of each speaker's communication competence (Watson et al., 2015). *Discourse management* addresses the communicative needs of each of the speakers in an interaction. It is concerned with process rather than content. Appropriate discourse management reflects active engagement in an interaction (e.g., encouraging engagement through the use of backchannels). In some situations (as shown in the analysis below), a playback serves the function of encouraging topic expansion. *Emotional expression and relation management* concern accurately recognizing an interlocutor's feelings, and in response demonstrating appropriate levels of concern and reassurance. Examples include participants' verbal (e.g. voicing concern when playing back the repeated item) and nonverbal cues (e.g. leaning forward). *Interpersonal control* addresses

power relations between interactants and focuses on the extent to which a participant is constrained to remain in his/her social or group role or is empowered to move out of his/her role. In the medical context, the doctor may constrain the patient's communication (e.g. through interruption and topic change), with the result that the patient is passive and plays a less powerful role in the interaction. Alternatively, the doctor may encourage the patient's communication (e.g. through encouraging topic expansion), with the result that the patient is active and has a more powerful role in the interaction. However, the way the participant manages the communication process) is intricately tied to his/her belief about the appropriate stance to adopt in medical interactions. For further details on CAT strategies, see Giles (2016).

The present study of playback explored the five CAT strategies and how they relate to the use of playback. We investigated a role-related difference in participants' use of playback and examined how playback allows the participants to align and build rapport while simultaneously serving the purpose of achieving appropriate accommodative stances. The objectives of the investigation reported here were to examine (i) how playback was constructed in TCM; (ii) what CAT strategies were used by the addressers in playing back; and (iii) how the analysis of different CAT strategies informs us about participants' efforts to accomplish both medical and interpersonal tasks. Answers to the last objective will help us better understand how CAT strategies work interdependently and how the micro-CAT features (actual communication behaviors) build into larger CAT strategies.

Methods and Data

Participants and materials

The data were drawn from a larger study investigating the differences between TCM and WM in relation to doctor patient communication and patient satisfaction. The data reported here include 30 TCM consultations between 3 doctors (all female) and 30 older adults with chronic diseases in a general public hospital in Mainland China. All the consultations were audio-recorded.

Older adults with the chronic disease chronic gastritis were chosen as the target group, as they constitute a large percentage of the patient population and represent a huge challenge in health care (Stuckler, 2008). While our specific sample were patients with chronic gastritis, these types of patients (older adults) usually came with a combination of more than one chronic disease. This conforms with the TCM belief that dysfunction in one part can affect the rest of the body.

Both doctors and patients were recruited from the Division of Internal TCM. Ethics approval was granted by both the researcher's home institution and the ethics committee of the hospital. Informed consent was obtained from all participants. Not all people approached agreed to participate in the project, as they were concerned about privacy. To protect their privacy, all participants' names were kept anonymous. Patient response rate was 32.9%. None of the patients were first-time visitors. The average patient age was 63 (SD = 7.8). The average length of a visit was 5.5 minutes (SD = 1.75). To test data consistency and coding consensus, the first author coded all the data twice, with a one-month interval. Test-retest reliability was 0.9 using Kappa

coefficient, demonstrating high consistency and validity (Porta & Last, 2018).

Procedures of analysis

All conversations were transcribed verbatim using Mandarin Chinese characters, following conversation analysis conventions (Jefferson, 2004). While the content was analyzed from the original language, the data were then translated into English for illustrative purposes. Regarding the conceptualization of playback, this study adapts Merritt's (1977) definition of playback as the immediate repetition of the name of the requested item in a service encounter.

Identification of playback in the two forms (queryback and affirmative playback) was mainly based on careful consideration of the syntax (e.g., a declarative or interrogative), the semantics of the utterance, and the next turn (Table 1).

<Table 1 about here>

Transcripts were read line by line and instances of playback were identified following two identification criteria. The sequential consequences of playback were examined based on (i) the recipient's responsive turn and (ii) the broader discourse management (e.g. whether the playing back of the repeated item extended or closed the current topic). While the semantics of Mandarin Chinese utterances are easier to capture based on the context, the syntax is more complicated, especially for people who are less familiar with Chinese. For example, in many non-tonal languages, the falling end intonation marks a declarative. In languages such as Chinese, however, the distinction between declarative and interrogative is more complicated, due to the interaction between tone and intonation (see Shen, 1990 for more discussions). In

Mandarin Chinese, an interrogative intonation could also have a falling tone (Tao, 1996). This aspect will be explored in the results.

In characterizing playback, first the forms of playback were examined, determining whether it is a queryback or an affirmative playback. Then, the two authors discussed the functions of playback in context, the effect on the subsequent discourse, and most importantly, the speakers' accommodative stance in deploying the playback. In determining which of the five CAT strategies was used by the speaker when playing back the other speaker's utterances, we found that the strategies were inter-dependent, and that the deployment of one strategy was often accompanied by the presence of one or more other strategies. Built on a belief that language is multi-functional and dynamic, we consider the practice of gauging the dominant CAT strategy as dangerous and biased. Rather, in our analysis, we tried to treat the playback as a resource of accommodation, the employment of which reflects a concurrent use of different CAT strategies.

To understand the functions, and consequences of playback in different forms, the current analysis examined the strategies a speaker employed by analyzing the immediate sequential consequence. Specifically, the authors analyzed how the recipient of the playback responds, for example, whether the recipient treats the playback as an invitation of extension or an indication of agreement.

The following section examines how, apart from displaying attentiveness, participants use playback as a strategy (in CAT terms) to accomplish instrumental tasks, while at the same time building rapport. In each of the following extracts, D

stands for doctor, P stands for patient, and F stands for family. The utterance under discussion is highlighted (marked by →) and the proposed CAT strategy is provided (marked by [ ]) at the end of the playback utterance. The 10 extracts featured below were chosen ~~from all the data available~~ as representative exemplars that most clearly showed how doctors and patients used queryback and affirmative playback invoked the CAT strategies (e.g. instances where they might indicate participants' use of more than one CAT strategy).

Findings

The Queryback

We observed three forms of queryback namely queryback with variation (syntactic and semantic changes), queryback with final particles (by adding a particle at the end of the utterance and thus changing statements into questions), and queryback with downward intonation (questions in the form of statements).

With variation. The excerpts demonstrated that most of the queryback was doctor-initiated, and was usually pronounced at a third position next to an answer to a question (Svennevig, 2004). Mostly, a doctor-initiated queryback was a repetition with variation – changing from statements into questions. Consider Extracts 1 and 2.

```
Extract 1
1 D zuijin dabian hai hao ba?
    do you have regular bowel movement?
2 P haode hai hao
     yes it is regular
3 →D hai hao shiba?  [Discourse management and interpretability]
     regular right?
```

4 P en(.)xianzai yitian- xianzai zhege shijian shuimian hai henhao
yes(.)now everyday- i have a good sleep these days

Extract 2

1 D xianzai weikou zenmeyang a weikou?
how is your appetite?
2 P weikou jiushi ()
appetite is()
3 D a?
ah?
4 P bu xiaode e de
i cannot feel hunger
5 →D bu xiaode e de shiba? [Discourse management and interpretability]
cannot feel hunger right?
6 P en(.)chi dou meiyou chi jiu bao le
um(.)i feel full after a few bites

These two conversations occurred in the history-taking stage. In Extract 1, the patient had a gallbladder polyp. In Extract 2, the patient had a gastric disease. In each of the two extracts, the doctor initiated a question by playing back the patient's statement to confirm understanding and offered an opportunity for repair. In so doing, the doctor displayed her accommodative stance by managing the communication process (i.e. utilizing discourse management) through the very act of ensuring interpretability. The queryback prompted further talk and reflected the doctor's engagement to the patient: passing the floor to the patient and inviting topic expansion rather than rushing the patient. The playback here probably displays the doctor's stance in acknowledging the patient as an active participant, and so demonstrates her

use of positive interpersonal control. The doctor's effort appeared to be recognized by the patient, as evidenced in the patient's responsive turn (line 4 in Extract 1, line 6 in Extract 2). The patient proceeded to give more evidence, displaying a mutual orientation towards information sharing and instrumental task completion (i.e. data collection). This information later constituted the basis for the doctors' diagnoses and treatment regimen.

With utterance-final particle. Alternatively, a queryback can also occur with an interrogative intonation (i.e. a final rising tone) (see Li and Thompson's [1981] chapter on questions) and an utterance-final particle (Wu, 2004). When formulated in this fashion, queryback reflects the speaker's orientation towards the forthcoming discourse as either patient extension or information confirmation. Consider Extract 3.

Extract 3

1 D hai hao ai ((physical examination))
  it is good
2 P ai wo zoulu zouqilai de
  yes i walked walked here
3 D ou
  oh
4 P wo zou le zou le 20 duo fenzhong cong nage nage ((location))nabian
  i walked walked at least 20 minutes from the ((location))
5 →D zou guolai de ou? [Discourse management and interpretability]
  walked here *ou*?
6 P ai(.)suoyi xianzai shi- wo pingshi shi shou hen liang de
  yes(.)so now is- my hands were very cold normally
7 →D shou hen liang de ou? [Discourse management and

interpretability]

very cold hands *ou?*

8 P enenen(.)yizhi yilai doushi hen liang de

um um um(.)always always cold

The patient in Extract 3 was considered to have a lack of vitality (in TCM terms, lack of yang'qi) (see Chan, 1995; Xu & Yang, 2009 for detailed discussion). Prior to line 1, the patient was complaining to the doctor that she had a low heartbeat. At line 1, the doctor examined the patient's heartbeat and told the patient that her situation was good, displaying disagreement with the patient's report. In so doing, the doctor might have been foregrounding emotional expression by providing reassurance about the patient's medical concerns. The doctor's positive evaluation of the patient's status was an attempt to reassure the patient and validate her concerns. Note here the patient's agreement-prefixed response at line 2: although she foregrounded convergence by showing agreement to the doctor's diagnosis, the patient indicated her disagreement by presenting new information. This information building extends to line 4. The queryback at the responsive turn (line 5) is most likely a reflection of the doctor's deployment of both the interpretability and the discourse management strategies, as evidenced by the patient affirmation and extension at line 6. Also the repeated use of queryback here (lines 5 and 7) reflects the doctor's use of discourse management. Rather than rushing the patient, the doctor allowed the information exchange in a clear and step-by-step manner. The doctor then diagnosed the patient as having a lack of vitality which served to explain the patient's current symptom of cold hands. Thus, the playing back here serves the function of data collection for the

completion of instrumental tasks.

The queryback also displays the doctor's engagement to the patient and her demonstration of attentiveness which reflects her agreement/acceptance of the patient's explanation. In so doing, the doctor was acknowledging the patient as knowledgeable of her own condition. The use of queryback here allowed the patient more conversational turns (lines 6 and 8). Seen in this light, the doctor was inviting the patient to engage in talk by allowing her more turns. This understanding of queryback is most notable at line 7, where the queryback contradicts the doctor's prior diagnosis (line 1). This contradiction adds weight to the treatment of playback as an indicator of the doctor's orientation towards the patient as an informative interactant rather than a passive participant (i.e. the utilization of positive interpersonal control).

Extract 4

1 P xianzai ganjue jiushi duzi zhang chidian dongxi ou wei wei-
now I feel my stomach is bloated and when I eat sth my stomach-

2 D bushi(.) ni ba ni zui bushufu de he wo shuo
no(.) just tell me where do you feel most uncomfortable

3 P wo jiushi duzi zhang tou yun
my stomach is bloated and I can't feel my head

4 →D tou yun a? [Discourse management and interpretability]
can't feel your head *a*?

5 P ai
yes

6 D zhege yun shi zaochen qilai yun haishi xiawu yun?
when? in the morning or afternoon?

7 P jiushi wanshang shuijiao yun
at night

8 →D wanshang shuijiao yun a? [Discourse management and interpretability]

at night *a*?

9 P ai touyun ou

yes i can’t feel my head oh

10 D ou

oh

11 P bushi changqi yun de

not lasting long

12 →D bushi changqi yun de a? [Discourse management and interpretability]

not lasting long *a*?

13 P ai

yes

14 D ou

Oh

A similar pattern may be observed in Extract 4, where the placement of queryback reflects the doctor’s concurrent deployment of discourse management and interpretability strategies. It is, however, worth noting that the doctor in Extract 4 displays a strikingly different stance to those in previous examples. This doctor communicates in a more directive manner. The patient was in her late 70s. At lines 1 and 2, instead of waiting until the patient finishes her problem presentation, the doctor halts the patient’s turn by showing explicit disagreement (‘no’ at line 2) and orients the following discourse as a problem presentation that only the ‘most uncomfortable’ experience should be discussed. This interruption may reflect the doctor’s orientation towards the patient as less effective in describing her own experience. Here, the doctor used interpersonal control and restricted the conversational turns of the patient

and claimed her authority and professional role in the interaction. Then, when patient problem presentation was at issue (lines 3, 7, and 11), the doctor formulated the queryback (lines 4, 8, and 12) in a fashion in which information confirmation was ongoing. At first glance, the doctor was ensuring interpretability (using queryback to clarify information). However, the fact that each of the querybacks occurred at a sequential place next to patient problem presentation suggests that the doctor was strategically managing the discourse to ensure completion of effective information gathering.

With downward intonation. In contrast to Merritt's (1977) observation, where the server's playing back of the client's utterance with downward intonation is considered as affirmative, those in this research are considered as a query, serving the function of confirming rather than showing agreement or indicating attentiveness (see the affirmative playback for more discussions). The queryback has a 'seemingly' declarative intonation (i.e. final downward intonation) which is salient in medical discourse. Unlike queryback discussed in the previous examples (i.e. with variation or with final particles), queryback formulated in this fashion does not invite elaboration. Consider Extracts 5 and 6.

```
Extract 5
1 P yisheng wo xiaobian jiechulai ne youpao
     doctor my urine is foamy
2 →D youpao [interpretability]
     foamy
3 P ai youpao
```

yes foamy

4 D ou(0.2)

oh(0.2)

5 (0.2)

6 D chi dongxi ne? chi dongxi zenmeyang

how about eating? how is eating?

Extract 6

1 D ni zheliangtian kesou gen yiqian de kesou youmeiyou shenme bianhua?

how is your cough these days compared with those before? any difference?

2 P bianhua jiu(.)chabuduo de

the difference is(.)more or less the same

3 →D chabuduo de [Interpretability]

more or less the same

4 P en

um

5 D doushi wanshang de?

all in the evening?

Each of these two extracts occurs at the history-taking stage. The use of queryback here reflects the doctor's deployment of interpretability and orientation towards the forthcoming discourse as means of information confirmation rather than information extension. It also demonstrates the doctor's priority at this stage of the medical consultation for efficient and accurate exchange of information (Street, 1991). This orientation was accurately captured and mutually developed by the patient, as evidenced by patient affirmation in the immediate next turn. It appears that both the doctor and the patient here treated the queryback as information confirmation

which is the relevant next activity. In so cooperating, both participants demonstrated a complementary accommodation (Street, 1991) by fulfilling the functions of each other's utterances.

Extracts 1 to 6 illustrate how queryback was used in medical discourse to perform instrumental (e.g. data collection), interactional (e.g. discourse management), and psychological (e.g. ensuring interpretability and indicating attentiveness) functions. The observation of doctor-dominated queryback in the present data could be an indicator of the doctor's accommodative stance in their interaction with older patients. Alternatively, the fact that queryback was predominantly used by doctors rather than patients also suggests the role difference in medical consultations, with the doctor taking the leading role in directing the conversation through the management of information flow.

The Affirmative Playback

In contrast to queryback, affirmative playback refers to playback without question intonation or interrogative particles (Merritt, 1977) and was primarily observed in the patient speech, the function of which is to register receipt (Schegloff, 1997) or show agreement. Consider Extract 7.

```
Extract 7
1 D lai shetou wo kanyixia
     come and show me the tongue
2 P haode
     ok
3 (0.5)((physical examination))
4 D haihaode
```

it looks good

5 →P haihaode ai [Accommodative interpersonal control]

it looks good yes

6 D haishi jidan?

still the egg?

This conversation takes place in the history-taking stage. The patient was diagnosed with a lack of vitality. At line 1, the doctor initiated a turn by directing the patient during a physical examination. The patient-initiated affirmative playback occurs at line 5, immediately after the doctor's positive diagnosis. Note that this repeated item (that the tongue looks good) is suffixed with an affirmative exclamation *ai*, reflecting the patient's accommodative stance towards the doctor by indicating agreement and acknowledging the doctor's expertise. Insofar as both participants demonstrated a mutual orientation towards the diagnosis of the patient's tongue as in good condition, the doctor shifted topic in the next turn. Thus, the affirmative playback here also serves the function of indicating medical task completion (i.e. physical examination).

Extract 8

1 P zhezhong tiepifengdou dou haochi de ma?

can i eat the ((name of the herbs))?

2 D buyao chi le

don't eat that

3 →P ai buyao chi le [Accommodative interpersonal control]

yes don't eat that

4 P tiepifengdou chi le wansahng huo wang

eating the herbs will make me hot ((a TCM concept)) at night

5 D shanghuo shi buhui shanghuo de(.)dui ni bu shihe

it will not make you hot(.)((but)) it does not fit you

6 P ou

oh

7 D ni shetou name dan

the color of your tongue is too light

8 P ou

Oh

A similar pattern was observed in Extract 8. This conversation takes place at the closing stage of the consultation. The patient was diagnosed with hyperglycemia. At line 1, the patient initiated the current diet discussion by asking the doctor if he could eat certain herbs. In response to the doctor's explicit disagreement, the patient displayed his agreement and indicated his compliance by an *ai*-prefixed affirmative playback. In agreeing, the patient aligned to the doctor's speech. This alignment is more notable in the patient's next turn (line 4), where he commented on the side effects of the herbs. Thus the patient acknowledged the expertise of the doctor and deferred to the doctor. Put differently, the affirmative playback reflects the patient's use of positive interpersonal control. This effort appears to be recognized by the doctor, who demonstrated complementary accommodation: by repairing the patient's speech through disagreement and explanation (line 5), the doctor claimed her expertise. Meanwhile, the explanation at line 5 is also a reflection of the doctor's use of interpretability by explaining the information in a clearer manner.

Extract 9

1 D ziji jian haishi daijian?

do you prefer to concoct ((the herbs)) on your own or leave it to us?

2 P ziji jian

on my own

3 (1.0) ((the doctor writes the prescription))

4 P zaochen wudianduo me jiu paqilai le

I got up at five plus this morning

5 →D ↑wudianduo jiu paqilai [Discourse management]

got up at five plus

6 P shuibuzhao le jiu paqilai le

I could not fall asleep so I got up

7 D ni wanshang jidian shuijiao?

when did you go to bed?

Extract 10

1 P jiu yijing buhe le

I have quit drinking

2 →D jiu yijing buhe le(.)juede zai bu chouyan jiu(.) meifa zuoren le [Discourse management and emotional expression]

you have quitted drinking(.)((so)) you feel if you quit smoking you will(.)you will rather die

3 P ai jiushi jiushi

yes that is right that is right

4 F hehe

heh heh

5 D na women zhe zhe

then we here here

6 P yuanben me xiang jiu jiediao

I was planning to quit drinking

7 P ruguo shuo yan jiejiao fan ye jiele

((but))if I quit smoking I would lose my appetite

On rare occasions, affirmative playback was observed in the doctor's speech. Consider Extracts 9 and 10. In contrast to its use in patient speech, the affirmative

playback here mainly serves the function of inviting patient elaboration (i.e. the utilization of discourse management), while at the same time showing empathy (i.e. emotional expression and relation management). In other words, by strategically maneuvering affirmative playback, the doctor accomplishes the dual tasks of instrumental task completion and rapport building. In Extract 9, the patient had a problem in sleeping. The doctor writing the prescription (line 3) marks a transition from the treatment negotiation to the closing stage. At line 5, the patient-initiated lifestyle discussion was played back by the doctor with a rising intonation (marked by↑), indicating her surprise. The doctor's articulation most likely reflected the use of discourse management and indicated engagement to the patient-initiated topic which resulted in the doctor successfully inviting patient extension (line 6).

In Extract 10, the patient had recently had a physical lung examination. Prior to line 1, he was discussing his physical report with his doctor. Some items on the report did not look promising. The doctor asked the patient to quit smoking. The doctor-initiated affirmative playback occurred at line 2, immediately next to the patient's complaint. Note that the playback here was directly followed by a humorous statement (if the patient quits smoking, he would rather die). At first glance, the playback-prefixed humor reflects the doctor's use of emotional expression. The doctor correctly pronounced the patient's psychosocial concerns (as evidenced by the patient's agreement), and in so doing the doctor displayed her empathy. The explicit agreement ('yes'), the continuous production of 'that is right' by the patient (line 3),

and the family's laughter also reflect the recipients' (i.e. the patient and the family) understanding of the playback as an indicator of the doctor's empathy. However, a closer inspection suggests that this playback-prefixed humor could also be an indicator of the doctor's deployment of discourse management. Specifically, rather than persuading the patient to quit smoking, the doctor took the perspective of the patient in order to encourage more patient participation, as evidenced by the patient's elaboration at lines 6 and 7. Given the multifunctional nature of utterances, rather than gauging which strategy is dominant, we consider that it would be wiser to see discourse as dialectic, as serving 'both-and'. Therefore, the playback-prefixed humor here serves the dual functions of both information elicitation and rapport building.

Extracts 7 to 10 illustrate the use of affirmative playback in medical discourse, primarily in the patient speech. Similar to the examination of queryback, the observation of affirmative playback also suggests role-related differences in its use in medical discourse. For example, patients use an affirmative playback to show agreement and acknowledge the doctor's expertise (i.e. positive interpersonal control), whereas the doctor uses an affirmative playback to invite patient elaboration (discourse management) and to show empathy.

Discussion

Functions of Playback and the Socio-Psychological Explanations

We examined the discourse functions and the accommodative stance assigned to playback in medical conversations. Our analysis shows that playback serves the dual functions of instrumental task completion and rapport building. A playback could be

formulated in a way that invites information giving, upon which medical diagnosis and treatment decision could be designed. However, a playback could also be formulated so that it maximizes the efficiency in collecting the necessary information for diagnosis, particularly when the patient is considered less efficient in describing his/her troubles (recall Extract 4 and see Adelman, Greene, & Charon, 1991). Finally, the deployment of playback could reflect the addressers' attentiveness and/or interests in engaging in extensive talk with the other interlocutor. Regarding participants' accommodative stance in the use of playback, the analysis suggests that both the doctor and the patient tend to take an accommodative stance that enables effective information collection and rapport building. Note that while the extracts presented here, which are brief, suggest that playback were frequently used for task completion. However, we did find instances where it could be used as a resource for rapport building (recall extracts 9 and 10). Given that none of the patients were first-time visitors, they may have had an established relationship with their doctors. This fact may also explain the short consultation time assigned to each patient because the doctors knew their patients quite well. Thus, while instances of rapport building were less explicitly observed in their present consultations, they did still occur and this line of investigation could be taken further in future research. What we presented here is a possible interpretation of the many functions of playback. Indeed, the very act that both participants tend to take an accommodative stance in the medical interaction via the use of playbacks could be an indicator of their orientation to rapport building. The

doctor employed accommodative discourse management to indicate encouragement of active patient participation. This included, for example, formulating the playback in a form of questioning, so that patient information giving is relevant. Doctors also used interpersonal control to either empower patients with more conversational turns (e.g., through the use of queryback with utterance-final particles) or restrict patient responses for the efficiency of information collection (e.g., queryback with downward intonation). Patients consistently took an accommodative stance by formulating the playback in an affirmative fashion to align to the doctor. Such behavior may reflect their respect for the doctor's expertise. An important feature of our results is the signaling of the psychological orientation (e.g., the motives and the goals) that drives interlocutors' use of playback in a situated interaction. The behavioral differences between doctors and patients in their use of playback could be readily mapped to the individual roles and tasks assigned by the society and the associated institutional norms.

Role-related difference in the use of playback

In the 10 extracts, we have illustrated the differences in participants' use of playback: the doctor used more queryback while the patient used more affirmative playback. Given the discourse functions of the two forms of playback, we consider that there is a mutual understanding or a shared knowledge between the doctor and the patient in their respective roles. First, the doctor realizes his/her interpersonal role in building rapport (e.g. the doctor's display of empathy). Second, both participants are aware of

their intergroup roles. The fact that most of the queryback was pronounced by the doctor suggests that the doctor is responsible for managing the discourse in medical interactions, determining the flow of topic and the closing of the interaction. The predominant use of affirmative playback in patient speech might indicate that the patient acknowledges the intergroup membership of the doctor as expert.

Implications and Future Directions

Our findings support Street's (1991) view that medical consultations are characterized by two patterns of accommodation: complementarity and convergence. In a complementary interaction, both the doctor and the patient display an orientation towards efficient information exchange as their priority. The professional role of the doctor is salient in the sequential context where playback is situated (e.g. the restriction on the patient responses). The power asymmetry is relatively more salient in complementary interactions than in convergent ones. In a convergent interaction, participants demonstrate a "mutually communicative involvement" (Street, 1991: p. 137). Thus, they use accommodative communication behaviors which encourages patient engagement (e.g. formulating the playback in a fashion that afford patients an opportunity to express themselves). The professional role of the doctor is not so pronounced, and an interactional balance is observed.

When considering the CAT strategies used by participants, the analyses find that discourse management is the dominant strategy among the CAT strategies deployed by speakers when playing back the other's utterances. One possible explanation is that whatever strategy is used, there must always be management of the discourse. For

example, when interpretability is used (i.e. to clarify information and to check understanding), the discourse is managed in a fashion that is mostly likely to either affirm or disaffirm. In our analysis, we constantly found, and explicitly demonstrated, that there are occasions when more than one CAT strategy is perceived. In other words, participants display their accommodative stance by incorporating more than one strategy at the same time. This finding emphasizes the robustness of CAT in explaining real-life discourse phenomena: that talk is multifunctional, participants engage in talk to accomplish multiple tasks, and that participants' stance may change as the conversation proceeds. In fact, the interdependency of the five CAT strategies is one of the complexities of CAT that requires further concentrated investigation. Our finding suggests that analysis of participants' accommodative stance in real-life interactions cannot be limited to one particular strategy. Rather, we propose that the actual accommodative stance should be the first consideration in an interaction.

Importantly, the study has also helped to develop our understanding of how repetition in languages other than English, for example Chinese, displays a systematicity similar to that of English (e.g. Kim, 2002; Svennevig, 2004). As Merritt (1977) observes, playback in service encounters (e.g. health encounters) could be formulated either in a fashion that requests a response or not. When requesting responses, the playback is typically pronounced with question intonation or interrogative particle (i.e. in the form of a queryback). One contrast with Merritt's (1977) observation is the role of playback with downward intonation. Our

examination suggests that playback with downward intonation mainly serves the function of a request for confirmation. Yet, this finding needs to be interpreted with caution given the differences between English and Chinese in linguistic structure. However, the fact that both languages, despite their semantic and syntactic differences, display a similarity in how a language feature (i.e. playback as a form of repetition) reflects the same accommodative meaning adds to CAT's strength in interpreting the dynamics of talk. It could also be informative to studies in intercultural communication where people's first language might affect their understandings of the other interlocutor.

Limitations and Conclusion

Given the difficulty of gaining hospital access (i.e., the difficulty in approaching all hospital divisions), this study is based on data collected from only one division, but there are other divisions such as acupuncture and recuperation under the broad category of TCM. Therefore, caution is required when interpreting these data. In addition, all the doctors included in this study were females. There could be some gender-related usages in the use of playback, which however is beyond the scope of our paper. Our paper focuses on doctors and older adults with chronic diseases, which while limiting generalizability, still captures an important and growing sub-group of the older adult population. It is possible that the use of playbacks demonstrates a different pattern in either first time consultations or in other medical contexts. In addition, this paper does not relate findings to participant opinions, e.g., whether

doctors' use of queryback makes patients feel respected and motivated, or whether patients' use of affirmative playback really indicates compliance with doctors' treatment regimen. These issues, too, are worthy of investigation for a better understanding of the consequences of playback in medical discourse. These limitations notwithstanding, the paper contributes to the understanding of the socio-psychological underpinnings of repetition, and playback more specifically. One of our major findings is that doctors and patients skillfully engage in formulating different types of playback, and that playbacks represent participants' various accommodative stances in medical consultations. In addition, the analysis displays the systematicity of repetition as a linguistic and communicative practice in languages other than English, and provides evidence on the robustness of CAT in explaining the motivations behind communicative practice and exploring the richness of talk.

References

Adelman, R. D., Greene, M. G., & Charon, R. (1991). Issues in physician-elderly patient interaction. *Aging and Society*, 11, 127-48. Doi: 10.1017/S0144686X00003974

Blackledge, A. & Creese, A. (2018). Interaction ritual and the body in a city meat market. *Social Semiotics*, Doi: 10.1080/10350330.2018.1521355

Boo, M. & Rose, M. L. (2011). The efficacy of repetition, semantic, and gesture treatments for verb retrieval and use in Broca's aphasia. *Aphasiology*, 25, 154-

175. Doi: 10.1080/02687031003743789

Chan, K. (1995). Progress in traditional Chinese medicine. *Trends in Pharmacological Science,* 16,182-187. Doi: 10.1016/S0165-6147(00)89019-7

Chevalier, B. M., Watson, B. M., Barras, M. A., & Cottrell, W. N. (2017). Hospital pharmacists' and patients' views about what constitutes effective communication between pharmacists and patients. *International Journal of Pharmacy Practice*, 26, 450-457. Doi: 10.1111/ijpp.12423

Ferrara, K. (1994). Repetition as rejoinder in therapeutic discourse: Echoing and mirroring. In B. Johnstone (Eds.), *Repetition in discourse: Interdisciplinary perspectives volumes II*. Norwood, New Jersey: Ablex Publishing.

Gallois, C. & Giles, H. (2015). Communication accommodation theory. In K. Tracy, C. Ilie, & T. Sandel (Eds.), *The international encyclopedia of language and social interaction* (pp. 159-176). Boston, MA: John Wiley & Sons.

Gallois, C., Watson, B. M., & Giles, H. (2018). Intergroup communication: Identities and effective interactions. *Journal of Communication*, 68, 309-317. Doi: 10.1093/joc/jqx016

Gallois, C., Weatherall, A., & Giles, H. (2016). CAT and talk in action. In H. Giles (Eds.), *Communication accommodation theory: Negotiating personal relationships and social identities across contexts* (pp. 105-122): Cambridge: Cambridge University Press.

Gallois, C., Wilmott, L., White, B., Winch, S., Parker, M., Graves, N., … Close, E. (2015). Futile treatment in hospital: Doctors' intergroup language. *Journal of*

Language and Social Psychology, 34, 657-671. Doi: 10.1177/0261927X15586430

Giles, H. (2016). The social origins of CAT. In H. Giles (Eds.), *Communication accommodation theory: Negotiating personal relationships and social identities across contexts* (pp. 1-12): Cambridge: Cambridge University Press.

Giles, H., Coupland, N., & Coupland, J. (1991). Accommodation theory: Communication, context, and consequence. In H. Giles, J. Coupland, & N. Coupland (Eds.), *Contexts of accommodation: Developments in applied sociolinguistics* (pp. 1-68). Cambridge: Cambridge University Press.

Harwood, J., Gasiorek, J., Pierson, H., Nussbaum, J. F., & Gallois, C. (2019). *Language, communication, and intergroup relations*. New York and London: Routledge.

Hewett, D. G., Watson, B. M., & Gallois, C. (2015). Communication between hospital doctors: Underaccommodation and interpretability. *Language & Communication*, 41, 71-83. Doi: 10.1016/j.langcom.2014.10.007

Huang, K. C. (1999). Preface to the second edition. In K. C. Huang *The pharmacology of Chinese herbs* (2nd ed.). US: CRC Press.

Hsieh, F. (2009). Repetition in social interaction: A case study on Mandarin conversations. *International Journal on Asian Language Processing*, 19, 153-168. Doi: 10.1109/IALP.2009.18

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner, (Eds.), *Conversation analysis: Studies from the first generation* (pp. 13-

31). Philadelphia, PA: John Benjamins.

Johnston, B. (2018). *Discourse analysis (3rd ed.)*. Hoboken NJ: John Wiley & Sons.

Jones, L. (2019). Institutional talk: Extending our understanding of intergroup communication in institutional settings. In J. Harwood, J. Gasiorek, H. Pierson, J. F. Nussbaum, & C. Gallois (Eds.), *Language, communication, and intergroup relations* (pp. 278-282). New York and London: Routledge.

Kim, H. (2002). The form and function of next-turn repetition in English conversation. *Language Research*, 38, 51-81.

Li, C. N. & Thompson, S. A. (1981). *Mandarin Chinese: A functional reference grammar*. Berkeley: University of California Press.

Merritt, M. (1977). The playback: An instance of variation in discourse. In R. W. Fasold & R. W. Shuy (Eds.), *Studies in language variation: Semantics, syntax, phonology, pragmatics, social situations, ethnographic approaches* (pp. 198-208). Washington DC: Georgetown University Press.

Morgan, S. E., Occa, A., Mouton, A., & Potter, J. (2017). The role of nonverbal communication behaviors in clinical trial and research study recruitment. *Health Communication*, 32, 461-469. Doi: 10.1080/10410236.2016.1140266

Nozari, N., Kittredge, A. K., Dell, G. S., & Schwartz, M. F. (2010). Naming and repetition in aphasia: Steps, routes, and frequency effects. *Journal of Memory and Language*, 63, 541-559. Doi: 10.1016/j.jml.2010.08.001

Porta, M. & Last, J. M. (2018). *A dictionary of public health (2nd ed.)*. Oxford University Press. Retrieved from

https://www.oxfordreference.com/view/10.1093/acref/9780191844386.001.0001/acref-9780191844386

Rakić, T. & Maass, A. (2019). Communicating between groups, communicating about groups. In In J. Harwood, J. Gasiorek, H. Pierson, J. F. Nussbaum, & C. Gallois (Eds.), *Language, communication, and intergroup relations* (pp. 66-97). New York and London: Routledge.

Roh, T. R. D. & Lee, Y-A. (2018). Teacher repetition as an instructional resource for classroom interaction: Three pedagogical actions in kindergartens in an EFL context. *System*, 74, 121-137. Doi: 10.1016/j.system.2018.02.008

Schegloff, E. A. (1997). Practices and actions: Boundary cases of other-initiated repair. *Discourse Processes*, 23, 499-545. Doi: 10.1080/01638539709545001

Shen, X-n, S. (1990). *The prosody of Mandarin Chinese*. Berkley: University of California Press.

Street Jr., R. L. (1991). Accommodation in medical consultations. In H. Giles, J. Coupland, & N. Coupland (Eds.), *Contexts of accommodation: Developments in applied sociolinguistics* (pp. 131-156). Cambridge: Cambridge University Press.

Stuckler, D. (2008). Population causes and consequences of leading chronic diseases: A comparative analysis of prevailing explanations. *Milbank Quarterly*, 86, 273-326. Doi: 10.1111/j.1468-0009.2008.00522.x

Svennevig, J. (2004). Other-repetition as display of hearing, understanding and emotional stance. *Discourse Studies*, 6, 489-516. Doi: 10.1177/1461445604046591

Tannen, D. (2007). *Talking voices: Repetition, dialogue, and imagery in conversational discourse (2nd Edition)*. Cambridge: Cambridge University Press.

Tao, H. Y. (1996). *Units in Mandarin conversation: Prosody, discourse, and grammar*. Amsterdam: John Benjamins Publishing.

Watson, B. M., Angus, D., Gore, L., & Farmer, J. (2015). Communication in open disclosure conversations about adverse events in hospitals. *Language & Communication*, 41, 57-70. Doi:10.1016/j.langcom.2014.10.013

Watson, B. M., Jones, L. & Hewett, D. G. (2016). Accommodating health. In H. Giles (Eds.), *Communication accommodation theory: Negotiating personal relationships and social identities across contexts* (pp. 152-168): Cambridge: Cambridge University Press.

Watson, B. M. & Soliz, J. (2019). Communication accommodation theory in institutional settings: Opportunities for applied research. In J. Harwood, J. Gasiorek, H. Pierson, J. F. Nussbaum, & C. Gallois (Eds.), *Language, communication, and intergroup relations* (pp. 242-264). New York and London: Routledge.

Wu, R-J. R. (2004). *Stance in talk: A conversation analysis of Mandarin final particles*. Amsterdam: John Benjamins Publishing.

Xu, J. & Yang, Y. (2009). Traditional Chinese medicine in the Chinese health care system. *Health Policy*, 90, 133-139. Doi: 10.1016/j.healthpol.2008.09.003

Tables

Table 1. Identification of Instances of Playback

Forms of playback	Examples	Syntax	Tone / intonation	Sequential next turn
Queryback	A: Do you have regular bowel movement? B: Yes, it is regular. →A: Regular right? B: Yes.	interrogative	Rising	Agreement / confirmation
Affirmative playback	((examination of the patient's tongue)) A: It looks good. →B: It looks good, yes. A: Still the egg?	Declarative	Falling / flat	A new topic