Physician-patient communication about patients' sexual activities and substance use: information exchange on potentially delicate matters

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PHYSICIAN-PATIENT COMMUNICATION ABOUT PATIENTS’ SEXUAL
ACTIVITIES AND SUBSTANCE USE: INFORMATION EXCHANGE ON
POTENTIALLY DELICATE MATTERS

by

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ABSTRACT

Previous interaction-based research has shown that physicians and patients collaboratively realize the routine character of comprehensive medical histories through their communicative behavior. A primary resource in this regard is the design of information seeking and reporting actions. Physicians seek information through closed-ended query formats and patients report information in fitted, minimal formats. This organization provides a relatively efficient way to address a wide range of health-related topics. One topical domain that has been described as sensitive and difficult is patient ‘lifestyle,’ which typically includes discussion of sexual activities and substance use. In these domains, patients engage in some special interactional work. They depart from the typical pattern of minimal, informational responses and instead provide responses that tacitly make a case for how their conduct should be understood. I argue that this special interactional work is designed, in part, to accomplish identity management. Specifically, I present evidence of two different identity management projects: the enactment of strong character and the restoration of character. Both projects involve patients’ efforts to portray themselves as normatively and/or morally appropriate. The enactment of strong character was accomplished through three interactional practices: (1) employing a syntactically, intonationally, or interactionally marked ‘no-type’ response; (2) volunteering normalizing details about the type, quantity, frequency, or circumstances of conduct; (3) evaluating conduct as normal or unproblematic. The restoration of character was accomplished through four interactional practices: (1) displaying independent awareness that reported lifestyle conduct is problematic; (2) mitigating personal agency in problematic lifestyle conduct; (3) framing problematic conduct as ‘in my past’
or already resolved; (4) employing quantity or frequency formulations that downplay the magnitude of problematic conduct.
INTRODUCTION AND RESEARCH PROBLEM

In a general practice setting, the processes of seeking and providing medical care require physicians and patients to discuss a wide range of health-related topics. Different topics can present different interactional or relational challenges for the participants. Some topics that have been identified as especially problematic are those that fall under the rubric of ‘patient lifestyle’ (or ‘social history’), an area that includes the topics of substance use and sexual activity. Previous research has shown that physicians and patients do not address these areas as routinely or as thoroughly as the medical education literature recommends (Clark, 1995; Maurice, 1998; Williams, 1995).

In a survey of 5,066 patients enrolled in 21 different health plans, Schauffler, Rodriguez, and Milstein (1996) found that only 10% of patients had ever communicated with their physicians about sexually transmitted diseases and only 9% patients had ever communicated with their physicians about alcohol/substance abuse. In a survey of 148 family physicians, 71% reported routinely taking a substance use history during a comprehensive medical history, while 42% reported routinely taking a sexual history. (Maheux, Haley, Rivard & Gervais, 1995). A survey of 33 family physicians who were seeing a patient for the first time revealed that a sexual history was performed less than half the time (Driscoll, Garner & House, 1986). In their analysis of 180 medical charts from a University-based family practice office, Graham, Zyzanski, Reeb, Sedlacek, and Emmitt-Myers (1994) found that a third of those charts contained no documentation of physician queries about alcohol use. Numerous researchers have argued that, even when information is exchanged on these matters, it is often too superficial to be particularly
useful (Friedmann, McCullough, Chin & Satz, 2000; Satterlund Larsson, Saljo & Aronsson, 1987; Maheux et al., 1995).

Various contextual factors affect the likelihood that these matters will be addressed in any given consultation. The nature of the patient’s presenting concerns is one important factor. In their survey of 600 general practitioners, Temple-Smith, Mulvey, and Keogh (1999) found that physicians are more likely to perform a sexual history when patients come to the visit with an explicitly sexual problem (92%) than with a non-sexual problem (30%). Bertakis and Azari (2007) report that physicians are much less likely to address substance use with patients who have multiple medical problems or concerns to discuss. Demographic characteristics also play a role. Male patients are more likely to receive a thorough substance use history than female patients (Satterlund Larsson et al., 1987), while younger patients are more likely to receive a substance use history (Mignon, 1993-94) and a sexual history (Maurice, 1998) than older patients. These patterns likely reflect certain ‘commonsense’ cultural expectations or stereotypes about the lifestyles led by members of these demographic categories.

While certain factors do increase the likelihood of discussions, the general consensus in the medical education literature is that these topics should be addressed as a matter of routine. Clark (1995) provides a fitting analogy: “Just as blood pressure should be routinely checked, so should alcohol problems be routinely screened for, as they are both highly prevalent and usually covert” (p. 28). Maurice (1998) echoes this sentiment regarding sexual matters: “Almost all patients should be given the opportunity to talk about a sexual concern in a health professional setting” (p. 18). Both physicians and patients agree that substance use and sexuality are legitimate and appropriate topics to
address in primary care contexts (Maurice, 1998; Ross & Landis, 1994; Temple-Smith et al., 1999; Williams, 1995), but these attitudes do not consistently translate into action during the consultation.

Researchers have offered various explanations for this, including such practical considerations as time constraints and lack of physician training in lifestyle history taking. But the most frequently cited barriers by far are those that relate to the normative and moral dimensions of these topics (Cotter & Callahan, 1987; Fleming, Barry, Manwell, Johnson & London, 1997; Kinnell, 2002; Klitzman & Greenberg, 2002; Maisto, Conigliaro, McNeil, Kraemer, Conigliaro & Kelley, 2001; Mattson & Roberts, 2001; Silverman, 1994; Silverman & Bor, 1991; Silverman & Perakyla, 1990; Weijts, Houtkoop & Mullen, 1993). Both physicians and patients are aware (and can expect one another to be aware) of the socio-cultural standards by which conduct in these domains might be evaluated. As a result, discussing these matters often engenders concerns about the moral positioning of the participants. Physicians report being concerned that their activities in these domains may seem insensitive, invasive, judgmental, or accusatory (Clark, 1995; Maurice, 1998; Mignon, 1993-1994; 1995; Rapley, May & Kaner, 2006; Williams, 1995). Patients report complementary concerns about feeling embarrassed or judged when discussing their conduct in these domains (Klaman, Grossman & Kopacz, 1999; Klitzman & Greenberg, 2002). Numerous researchers and medical practitioners have argued that these concerns constitute a significant impediment to the provision of comprehensive medical care and have called for research that explores the communicative challenges and complexities that physicians and patients are dealing with when they discuss lifestyle.
In this analysis, I employ the notion of ‘identity’ as a conceptual tool for understanding patients’ and physicians’ activities during lifestyle history taking. Specifically, I rely on the dramaturgical framework of Erving Goffman (1955; 1959; 1963; 1967; 1971), which emphasizes the emergent construction of identity through interactional behavior (or social ‘performances’).

Identity is a broad concept, one that is used differently for different disciplinary and analytic purposes (see Widdicombe, 1998 for an overview of different treatments), but I would argue that it is well suited to analyzing lifestyle history taking. Because lifestyle health is generally understood to be a function of voluntary behavioral choices, these choices can provide a glimpse into the nature of the actor who made them. When patients are describing their lifestyle conduct, they might be rightly concerned with what this information could implicate about the sort of person they are (i.e. their ‘identity’). If they have such concerns, it is important to understand the ways in which, and the extent to which, they appear to influence the shape of lifestyle history taking. Understanding these identity concerns and their interactional manifestations may allow us to identify specific communicative challenges within the history as well as pathways to overcoming them.

I employ a single exploratory research question for this analysis:

*RQ1: In what way(s) is ‘lifestyle’ history taking shaped by concerns about identity?*
LITERATURE REVIEW

This study of physician-patient interaction in ‘lifestyle’ domains draws on and contributes to two broad literatures: 1) health communication and 2) language and social interaction. In this chapter, I review a range of conceptual themes and empirical findings within each literature.

Health Communication

Within the broader area of health communication, there is a sizeable literature that focuses on provider-patient relationships/communication/interaction. In this section, I review three relevant streams of research in this literature. First, I describe the purposes, structures, and interactional dynamics of routine (comprehensive) history taking, focusing on the challenges of communicating in so-called ‘lifestyle’ domains. I then review research that addresses provider-patient communication in each of the two focal lifestyle domains: substance use and sexual activities.

Routine Comprehensive History Taking

History taking is an institutionalized form of information exchange in which physicians seek health-related information from patients in a systematic, goal-oriented fashion. Depending on the circumstances and purposes of the medical encounter, history taking can take different forms. If a patient is being seen for an acute symptom or complaint, the physician’s history taking will be designed to produce a differential diagnosis. This involves probing for specific information/evidence that could confirm or disconfirm emergent medical explanations (Frankel, 1994; Frankel & Beckmen, 1989; Mishler, 1984; Robinson & Heritage, 2005; Roter & Hall, 1992). A routine comprehensive medical history is organized for different purposes. Typically performed
with all new patients and during annual checkups, a routine medical history is designed to collect information on a range of general health matters (Boyd & Heritage, 2006; Stivers & Heritage, 2001). Comprehensive medical histories are typically organized as a series of smaller component histories, clusters of topically related queries that are designed to address specific aspects of a patient’s health status or history. Some examples of these component histories include: past and present medical conditions, prior surgeries and/or hospitalizations, medications, overviews of bodily systems (cardiovascular, gastrointestinal, etc.), and family history.

It should be noted that comprehensive history taking does not preclude the possibility of more symptom-focused, differential diagnostic history taking (Boyd & Heritage, 2006). Because comprehensive histories involve systematic attention to a broad range of health domains, they afford opportunities for patients to report specific symptoms or complaints in these domains. When a patient does so, physicians may shift the focus of their queries to the exploration and diagnosis of the complaint. Likewise, patients’ reports in these domains may reveal problems that they had not considered or defined as problems. Physicians may seek additional information to explore the scope of these potential problems. At some point, the physician typically will return to the comprehensive history and the ‘checklist’ of key health topics to be covered. Thus, comprehensive history taking can occasion the discovery of health concerns and also structurally accommodate more diagnostically oriented history taking.

There has been considerable research on the interactional structure and organization of history taking (Ainsworth-Vaughn, 1998; Heritage & Sorjonen, 1994; Robinson, 2003; Robinson & Stivers, 2001), including research focused specifically on
routine history taking (Boyd & Heritage, 2006; Stivers & Heritage, 2001). Research on routine history taking has emphasized how physicians and patients collaboratively realize the routine character of this activity through their interactional conduct. Physicians generally employ standardized, depersonalized, fixed-choice query formats that structurally prefer ‘no problem’ responses and patients generally provide minimal, type-conforming responses. Routine history taking is conceptualized as an activity framework that provides for maximally efficient information exchange over a wide range of health-related matters.

Although we know a good deal about the general features of routine history taking as an interactional activity, we know much less about how that activity is managed across the various topical domains that systematically emerge during the course of a routine history. Up to this point, very little research has closely examined the smaller component histories (and the topical domains to which they are directed) that actually comprise the routine history. These component histories involve an extremely wide range of health-related topical domains, each of which may be bound up in distinctive cultural meanings and concerns. These meanings and concerns can ultimately have a bearing on how the practical activity of routine history taking is accomplished. This study addresses the complexities involved in addressing a cluster of related component histories often described under the rubric of social history taking, or patient ‘lifestyle.’

**Social History Taking: Discussing Patient ‘Lifestyle’**

There are some variations in the specific topical domains that are included under the heading of ‘lifestyle,’ but generally they include substance use (tobacco, alcohol, and illicit drugs), sexual activities (partnerships, sexual (dys)function, birth control, STI
prevention), diet, and exercise. This review addresses only the domains of substance use and sexual activities.

One of the distinctive elements of lifestyle history taking is the emphasis on patients’ conduct, the more or less voluntary behavioral choices that patients make in their everyday lives. This sense of volition is not necessarily present in other topical domains within a routine medical history. Many aspects of illness and wellness are understood to be beyond one’s control. For example, catching a contagious illness (e.g. influenza) or developing a condition to which one is genetically predisposed (e.g. migraine headaches) are understood in commonsense terms as acting upon that person from some external locus of control (i.e. they happen to that person). Lifestyle matters are different in this regard. Loosely speaking, a patient may choose to smoke cigarettes or choose not to (though once they choose to, it becomes increasingly difficult to choose not to). These types of choices can expose patients to, or insulate them from, various health risks. As previous researchers (Boyd & Heritage, 2006; Pilnick & Coleman, 2006; Rapley, May & Kaner, 2006; Satterlund Larsson, Saljo & Aronsson, 1987; Stivers & Heritage, 2001) have argued, to the extent that these health risks are understood to be a product of their choices and conduct, patients may feel that their moral character, their identity as responsible health citizens and persons, is powerfully implicated in the domains of lifestyle.

Another distinctive feature of lifestyle matters is that they are understood to occupy a middle ground between two different frames of understanding: a medical frame and a “lifeworld” (Mishler, 1984) frame. To be sure, substance use and sexual activities are medically relevant and consequential; there is widespread agreement even among
patients that health care should include attention to these matters (Graham, Zyzanski, Reeb, Sedlacek & Emmitt-Myers, 1994; Ross & Landis, 1994). But these activities also have social and cultural meanings that are bound up in patients’ lived experiences. There is often confusion and ambivalence about the best ways for physicians and patients to navigate between these two frames. Whereas physicians are understood to have asymmetrical expertise in the medical frame, that asymmetry may not translate as clearly in matters of lifestyle (Johanson, Satterlund Larsson, Saljo & Svardsudd, 1998), where patients’ understandings and interpretations are also relevant. In their analysis of Finnish physicians and patients, Sorjonen, Raevaara, Haakana, Tammi, and Perakyla (2006) suggested that physicians apply certain interactional restrictions to the health promotion aspects of their work: “We could try to capture these restrictions into a putative norm of conduct that suggests that the doctor should respect the integrity of the patient’s evaluation of his or her lifestyle” (p. 377).

There have been relatively few studies of routine lifestyle history taking, but the available literature suggests that these domains involve a range of challenges and complexities, many of which center on issues of morality and identity. A persistent theme in this literature is that discussing lifestyle with one’s physician may engender concerns about the perceived (im)morality or normative (im)propriety of one’s conduct. Patients may be concerned that their reported conduct in these domains could serve as a basis for face-threatening identity attributions (Boyd & Heritage, 2006; Mignon, 1995; Silverman, 1994; Silverman & Bor, 1991; Thom & Tellez, 1986). At the same time, physicians have expressed concern that their lifestyle queries may seem invasive, embarrassing, or accusatory to patients and report feeling ill-equipped to approach these topics (Clark,
1995; Cotter & Callahan, 1987; Friedmann, McCullough & Chin, 2000; Maly, 1993; Maurice, 1998; Mignon, 1995; Rapley et al., 2006; Roche & Richard, 1991; Temple-Smith, Mulvey, & Keogh, 1999). Researchers have related these concerns to a general disinclination among both physicians and patients to discuss lifestyle issues in primary care contexts. Research has shown that the discussions that do occur tend to exhibit considerable delicacy and circumspection (Rapley et al., 2006; Silverman & Bor, 1991; Weijts, Houtkoop & Mullen, 1993). A chief concern is that the delicacy of these topics tends to lead to superficial history taking and ultimately under-identification of potential medical problems. On the basis of these findings, numerous researchers and medical practitioners have called for increased research attention to the interactional dynamics of history taking in lifestyle domains.

Provider-Patient Communication About Substance Use

In this section, I discuss literature that reviews some of the complexities and challenges involved in communicating about substance use in health care settings. I also discuss literature that reviews some of the communicative strategies that have been proposed to deal with these challenges. It should be noted that most of this research emphasizes the provider’s perspective, the challenges s/he faces and the strategies that s/he may use to more effectively communicate with patients. Even when patient’s communicative activities are more focal (e.g. Blaxter & Cyster, 1984; Coleman, Stevenson & Wilson, 2000; Halkowski, 1998), the emphasis is still on informing and empowering physicians with resources to understand and deal with what their patients are doing. This likely reflects certain unstated premises about physicians’ authority and initiative in organizing and structuring medical encounters as well as the belief that
communication-oriented interventions are best directed at the professional member of the provider-patient dyad.

Obstacles to Effective Communication

In this subsection, I describe three types of obstacles to effective provider-patient communication about substance use: cognitive obstacles, communicative obstacles, and institutional/organizational obstacles.

Cognitive obstacles

Research has shown that physicians often develop pessimistic attitudes toward patients with substance use problems, viewing them as deceptive, difficult, and noncompliant (Maly, 1993; Mignon, 1993/94; 1995; 1996; Najman, Klein & Munro, 1982; Rapley et al., 2006; Thom & Tellez, 1986). This can lead to a generalized disinclination to probe for potential substance use issues, as this may uncover problems that are perceived to be frustrating or insoluble. Research has also shown that physicians are concerned with maintaining rapport with patients, rapport that may be threatened if they appear to be moralizing or judging (Clark, 1995; Mignon, 1993-94; Pilnick & Coleman, 2003; 2006; Rapley et al., 2006; Satterlund Larsson et al., 1987; Thom & Tellez, 1986). Some research has identified concerns about the competing normative frameworks that may be at play in discussions of substance use, where the same conduct may be viewed differently from a medical framework and a socio-cultural framework. Physicians express concern about the legitimacy of medicalizing and problematizing conduct that patients experience as private and, in some cases, as normatively appropriate within their communities (Blaxter & Cyster, 1984; Satterlund Larsson et al., 1987; Thom & Tellez, 1986). Moreover, physicians may feel that their efforts to encourage healthy
patterns of substance use are undermined by the larger cultural and informational environments into which those messages are cast. As Thom and Tellez (1986) argue, “It is unrealistic to expect general practitioners to respond enthusiastically to the task of detecting and managing alcohol problems while political and economic interests sustain public beliefs and attitudes toward drinking which make it difficult for doctors and patients alike to acknowledge the existence of alcohol problems” (p. 419).

Communicative obstacles

The cognitive obstacles described above all essentially involve physicians’ willingness to discuss substance use with patients. But even when physicians are willing, there are communicative obstacles that can affect the quality of care provided. Physicians frequently cite lack of training and lack of specialized communication skills as barriers to addressing substance use with patients (Clark, 1995; Cotter & Callahan, 1987; Friedmann et al., 2000; Maly, 1993; Mignon, 1995; Rapley et al., 2006; Roche & Richard, 1991). A range of specific communicative issues and challenges have been cited, including: 1) How/when can physicians initiate/topicalize substance use discussions? (Johanson et al., 1998; Satterlund Larsson et al., 1987; Sorjonen et al., 2006); 2) How can physicians seek information without appearing to suspect or accuse patients of having a substance problem? (Clark, 1995; Mignon, 1995; Thom & Tellez, 1986); 3) How can physicians advise changes in substance use without appearing to judge or sanction patients? (Pilnick & Coleman, 2006; Rapley et al., 2006; Thom & Tellez, 1986); 4) How can physicians deal with patients’ resistance or noncompliance? (Blaxter & Cyster, 1984; Pilnick & Coleman, 2003; 2006). As with the cognitive obstacles, these communicative challenges
and complexities can lead to a disinclination to thoroughly address substance use in
general practice settings.

Institutional/organizational obstacles

Some barriers to effective communication stem from larger institutional norms
and practices. One of the more frequently cited barriers to addressing substance use is
time constraints (Friedmann et al., 2000; Rapley et al., 2006; Taj, 1998; Thom & Tellez,
1986). While physicians acknowledge the serious health consequences associated with
substance use, time constraints lead physicians to prioritize patients’ current, acute
symptoms (often the reason the patient made the appointment) over preventive health
issues. The lack of incentivization for substance use issues have also been cited (Rapley
et al., 2006). Physicians are often rewarded for helping patients to manage chronic
illnesses such as diabetes. These types of ‘quality indicators’ have also been applied to
cigarette smoking, but not alcohol or illicit drugs. Absent these incentives, and the
institutional mandate and support they can communicate, there is little reason for
physicians to be motivated to identify and manage alcohol and drug issues. Finally, there
is a range of issues related to physicians’ construction of their professional role (i.e.
obligations and entitlements) as it relates to patients’ substance use. Many physicians are
ambivalent about their role in treating substance use, abuse, or addiction as medical
problems (Thom & Tellez, 1986; Rapley et al., 2006; Roche & Richard, 1991; Wright,
(19 out of 26) questioned the very disease concept of alcoholism, essentially de-
medicalizing it. Many physicians see their role primarily as a hub through which patients
can be put in contact with other, more ‘appropriate’ institutionalized services, such as mental health settings or AA meetings (Thom & Tellez, 1986; Rapley et al., 2006).

**Strategies for Effective Communication**

In this subsection, I describe a range of communication strategies and practices that have been proposed to help physicians address substance use in medical consultations. I organize these strategies around three communicative activities that have been treated as particularly challenging: raising the topic of substance use; seeking information about substance use; intervening in substance use.

**Raising the topic of substance use**

Many physicians report difficulties in raising substance use as a topic for discussion in medical interviews. The ways in which these topics are raised can have a powerful bearing on the sense that patients make of their being raised. Researchers have identified several strategies that may be effective in managing this task. Interestingly, these strategies appear to make use of both depersonalization and personalization as resources for framing the meaning and purpose of topicalizing substance use. Many of these strategies also reflect physicians’ commitment to not raising these matters ‘out of the blue,’ where patients may be confused about their relevance to the business at hand (Rapley et al., 2006).

One strategy that medical practices employ is the use of pre-consultation screening instruments, essentially paper surveys that allow patients to report on their substance use before meeting in person with their physician. Physicians can then use these completed forms as a vehicle for raising these topics and following up during the consultation (Maisto, Conigliaro, McNeil, Kraemer, Conigliaro & Kelley, 2001; Maly,
This serves to frame these topics in terms of routine, generalized practice, which works against the appearance that the physician suspects a substance use issue. This type of depersonalization can also be accomplished during the consultation by physicians’ prefacing substance use histories with phrases such as, “I have some general medical questions…” or “Here are some questions I ask everyone…,” where these prefaces resist the sense that substance use queries are uniquely necessary for this patient (Rapley et al., 2006). This sense of routine, generalized practice can also be accomplished more implicitly by positioning substance use queries within other topical environments. Some physicians inquire about cigarette smoking while examining a patient’s mouth, such that the topic appears to emerge in a natural context (Satterlund Larsson et al., 1987). Some physicians inquire about alcohol just after discussing eating habits, such that alcohol is understood as a routine next topic in a larger checklist concerning ‘consumption’ (Rapley et al., 2006; Sorjonen et al., 2006).

Whereas these strategies tend to depersonalize the warrant for raising substance use as a topic, other strategies involve personalized warrants that legitimize raising the topic. The most frequently cited strategy in this regard is associating the substance use queries with a current health concern or problem (Johanson et al., 1998; Pilnick & Coleman, 2006; Rapley et al, 2006; Sorjonen et al, 2006; Thom & Tellez, 1986). Insofar as the patient’s substance use may exacerbate a medical condition or interfere with treatment protocols, physicians report feeling on more solid medical ground to raise these issues.
Seeking information about substance use

Even after substance use has been raised as a topic, there are still concerns about the most effective ways to seek information from patients, where ‘effectiveness’ can be measured in terms of the capacity to elicit useful information and in terms of the respect and sensitivity of the approach. Many physicians report feeling comfortable asking an initial substance use query, essentially topicalizing the matter, but are reluctant to probe more deeply for potential problems (Satterlund Larsson et al., 1987; Rapley et al., 2006). A good deal of research, particularly in medical literature, has focused on screening instruments that physicians can deliver orally during the consultation. These screening instruments are typically banks of questions that have been proven to be reliable in assessing potential substance issues. One of the more frequently cited instruments for alcohol issues is the CAGE test, a simple, four item test that has been praised for its reliability and sensitivity. Chrpitel (1997) and Clark (1995) review a range of other screening instruments similar in form and function to the CAGE test.

A smaller body of research has identified forms of indirectness and depersonalization that physicians may use in formulating their information seeking activities. For example, examining Swedish data, Satterlund Larsson et al. (1987) show that physicians often use indirect formulations that leave out the verb “to drink” (dricka), instead using formulations such as “And what about liquor?” or “Alcohol and such things, how much?” They also show that physicians leave out personal pronouns such as “You.” These kinds of strategies may serve to subtly defang queries that might otherwise seem invasive, accusatory, or face threatening.
Intervening in substance use

When a physician’s information seeking activities reveal a potential problem with substance use, they may elect to intervene. In the domain of substance use, physicians’ interventions typically take the form of advice to reduce or suspend consumption. When physicians offer this kind of advice, they are often concerned to avoid the appearance of judging, criticizing, sanctioning, or ‘nagging’ the patient (Pilnick & Coleman, 2006; Rapley et al., 2006; Sorjonen et al., 2006; Thom & Tellez, 1986). Various strategies have been proposed to help physicians balance the need to encourage positive health behaviors with the need to maintain rapport.

One broad strategic approach is essentially an outgrowth of physicians’ information seeking activities. In seeking information, physicians can tacitly work to problematize patients’ substance use. For example, in seeking information about cigarettes smoking, a physician may ask a patient if s/he has experienced related symptoms, such as coughing or fatigue. While this is an information seeking action on the surface, the patient’s answer can serve to problematize his/her smoking without the physician having to do this unilaterally. Once problematicity is mutually secured, the groundwork for providing medical advice has been laid (Pilnick & Coleman, 2006; Sorjonen et al., 2006). This approach makes use of what Maynard (2003) describes as a perspective display sequence. By first eliciting a recipient’s perspective on some matter, a speaker can tailor or adapt his/her own perspective to what the recipient has already displayed. Maynard has shown how this can serve as a relatively sensitive or empathic strategy for health professionals to deliver bad news to clients.
Another approach that builds in the patient’s perspective is tailoring intervention efforts to the patient’s displayed readiness or resistance to alter their substance use. Coleman et al. (2000) developed a coding scheme to help physicians recognize patients’ communicative behaviors as displaying either readiness or resistance to quit smoking. By offering advice to patients who have displayed (either tacitly or explicitly) readiness to quit, physicians can capitalize on an auspicious environment for advising. In an environment in which the patient is signaling readiness to quit, the physician’s advice is more likely to be understood as supportive and empowering, not nagging or meddling. Likewise, when a patient signals resistance, a physician may be better served to avoid unwelcome advice.

As previously noted, physicians often work to associate substance use concerns with other kinds of medical consequences; those consequences can serve to create an exigency for the patient to address substance use (Johanson et al., 1998; Pilnick & Coleman, 2006; Rapley et al, 2006; Sorjonen et al, 2006; Thom & Tellez, 1986). By associating substance use with other medical consequences, physicians can urge patients to curb their use without treating abuse or addiction as the primary medical problem. This resists labels such as alcoholic or drug abuser, which may reduce patients’ defensiveness.

Provider-Patient Communication About Sexual Activities

The domain of sexuality is arguably more diffuse and complex than the domain of substance use. A wide range of issues may be subsumed under the broad heading of sexuality: current and former sexual partnerships, sexual activities, sexual dysfunction, birth control practices, STI status and prevention practices, infidelity, sexual abuse, and more. It is beyond the scope of this review to consider each of these areas in detail. The
emphasis here is to provide an overview of the challenges that have been identified and the solutions that have been offered in the medical and social scientific literature on sexual health discussions.

It should be noted that a fair amount of the research cited in this section is not based in general practice settings. Starting in the 1990s, there were a series of studies published on interaction during HIV test counseling (Kinnell, 2002; Kinnell & Maynard, 1996; Perakyla & Bor, 1990; Silverman, 1994; 1997; Silverman & Bor, 1991; Silverman & Perakyla, 1990; 1992), essentially a counseling and support service that clients would receive when they went to a clinic to be tested for HIV. HIV test counseling is a form of provider-patient interaction, but the provider is not a physician, nor is s/he responsible for the ongoing care of the patient. Nonetheless, this literature provides a detailed glimpse into a range of challenges and solutions that may be relevant to physician-patient interaction on sexual matters.

Obstacles to Effective Communication

In this subsection, I describe two types of obstacles to effective provider-patient communication about sexual matters: cognitive obstacles and communicative obstacles. While some research cited time constraints as an obstacle, this literature appears less focused on these kinds of institutional/organizational obstacles.

Cognitive obstacles

In the last 20-30 years, researchers have found that some physicians hold negative attitudes toward patients whose sexual activities or lifestyle could be considered normatively deviant, including sex workers and especially homosexuals (Gerbert, Maguire, Bleecker, Coates & McPhee, 1991; Klitzman and Greenberg, 2002; McGrory et
al., 1990; Najman, Klein & Munro, 1982; Ross & Landis, 1994; Williams, 1995). There has been a tendency to associate these populations with HIV/AIDS, which has led to further stigmatization of these groups in health care. While some of this research is a bit dated, a relatively recent study of homophobia among medical students (Klamen, Grossman & Kopacz, 1999) indicated significant homophobia among a generation of physicians who are presumably currently practicing medicine. These negative attitudes may make physicians reluctant to address sexuality with patients for fear of discovering activities of which they disapprove. Even when physicians do not disapprove of homosexuality, they may feel that they lack knowledge about the sexual practices of homosexuals and may avoid the topic for fear of exposing their own professional limitations (Maurice, 1998).

Other research has shown that embarrassment represents a serious obstacle to sexual history taking (Floyd, Lang, Beine & McCord, 1999; Maheux, Haley, Rivard & Gervais, 1999; Maurice, 1998; Ross & Landis, 1994; Temple-Smith et al., 1999; Williams, 1995). In the domain of substance use, physicians seem primarily concerned with the maintaining a level of comfort for the patient, but in the domain of sexuality, physicians report being concerned not just with patients but with their own comfort as well. Some factors may exacerbate the level of embarrassment experienced or anticipated. For example, Maurice (1998) reports that younger physicians are particularly wary of discussing sexual matters with older patients, likening it to talking about sex with one’s parents.

Additionally, some research has shown that physicians are concerned about accusations of sexual misconduct (Maheux et al., 1999; Maurice, 1998). Given the
delicacy of the issues involved and the vulnerability of the patient (who is often partially undressed during the consultation), there are certainly opportunities for misinterpretations of physicians’ questions. Again, these concerns may lead physicians to be less explicit and less thorough than the medical training literature suggests they should be.

**Communicative obstacles**

As with substance use, physicians consistently cite lack of communication skills and training as obstacles to addressing sexual issues with patients (Floyd et al., 1999; Gerbert et al., 1991; Maheux et al., 1995; Maurice, 1998; Temple-Smith et al., 1999). Perhaps not surprisingly, the specific communicative challenges that physicians report closely mirror those reported for substance use: 1) How/when can physicians initiate/topicalize sexual matters? (Floyd et al., 1999; Maurice, 1998; Williams, 1995); 2) How can physicians seek information while minimizing embarrassment? (Andrews, 2000; Floyd et al., 1999; Maurice, 1998; Williams, 1995; Weijts et al., 1993); 3) How can physicians advise changes in sexual conduct without appearing to judge or sanction patients? (Kinnell & Maynard, 1996; Silverman, 1997; Silverman & Perakyla, 1992); 4) How can physicians deal with patients’ resistance or noncompliance? (Kinnell & Maynard, 1996; Silverman, 1997). As with the cognitive obstacles, these communicative challenges and complexities can lead to a disinclination to thoroughly address sexual matters in general practice settings.

**Strategies for Effective Communication**

In this subsection, I describe a range of communication strategies and practices that have been proposed to help physicians address sexual matters in medical consultations. I organize these strategies around three communicative activities that have
been treated as particularly challenging: raising sexual matters as a topic; seeking information about sexual matters; intervening in sexual conduct.

**Raising sexual matters as a topic**

The strategies that researchers and practitioners have offered for raising sexual topics mirror in spirit those offered for topicalizing substance use. That is, there is a concern for not raising the topic ‘out of the blue,’ but rather finding natural transition points in the consultation. For example, Williams (1995) recommends that a sexual history could be taken opportunistically if a patient mentions having a partner. If such an opportunity does not arise, she suggests that a sexual history could be implemented during a routine genito-urinary systems review or gynecological systems review. In either case, this topical/sequential positioning would suggest that the sexual history is simply one more routine matter to be addressed. Maurice (1998) makes a similar suggestion about incorporating sexual history questions into a routine personal or social history (e.g. employment, household arrangements, pets, etc.), where sexuality can be understood as one of a range of psychosocial topics that the physician routinely covers. Maurice however discourages physicians from taking a sexual history during physical examination, as this may invite concerns about misconduct or impropriety. Maurice also proposes that practitioners can explicitly seek permission to query patients about sexual matters. This gives patients a sense of control over the topic and can alleviate physicians’ concerns about intruding. Andrews (2000) reports that some physicians work to establish a level of comfort by employing pre-consultation screening instruments that essentially forecast that sexual matters will be discussed during the consultation.
Seeking information about sexual matters

Some research in the medical literature has emphasized the content of sexual history taking, essentially the topics should ideally be covered (e.g. Andrews, 2000). But, as Maurice (1998) argues, “what appears to be missing from interviewing textbooks directed toward health professionals are suggestions about how to ask sex-related questions, quite apart from what to ask. The nature of questions may be less disconcerting to patients than the way in which questions are asked” (p. 26, emphasis in original).

Drawing on interaction-based literature (and select medical literature), myriad proposals have been made about ways to effectively seek sex-related information.

There are differing views on the directness/indirectness with which sex-related questions should be formulated. Williams (1995) suggests that physicians might start with direct, closed-ended questions (e.g. Do you experience any trouble having an orgasm?) and then, if necessary, shift to a more open-ended question (e.g. Can you tell me more about that?). The rationale is that the more direct initial question can help to introduce specific matters that the patient might be reluctant to volunteer. On the other hand, Silverman (1994) argues that indirect forms of speech can represent a form of tact, acknowledging the potential delicacy of the matters in question. Even the use of speech dysfluencies and perturbations (e.g. “er” and “um”) can propose or display the speakers’ stance that the matter in question calls for a measure of care and circumspection (Silverman, 1994; Silverman & Bor, 1991; Silverman & Perakyla, 1990; Weijts et al., 1993).

Researchers have also pointed out the need for practitioners to be attentive to their choices in vocabulary. Williams (1995) suggests that physicians should avoid
euphemisms and clarify any unfamiliar terms/phrases that patients use. She recommends that physicians begin with relatively formal medical terms and shift to informal ones only when the patient seems more comfortable or familiar with those. Maurice (1998) warns against the use of technical medical jargon and suggests that physicians should assume patients need some terms to be defined as a matter of course. On the other hand, Weijts et al. (1993) report that the Dutch gynecologists they observed routinely used euphemisms when interacting with patients. For example, they used the phrase ‘down there’ to refer to the patient’s vagina. In one case, a practitioner made a very oblique reference to the possibility of childhood sexual abuse to help explain a patient’s sexual dysfunction, which the patient recognized and denied. They also report that gynecologists would sometimes omit delicate terms altogether and use pronouns excessively in order to avoid explicitly sexual terms. All of this was ostensibly done in order to acknowledge the potential delicacy of the matters in question and to make patients (and perhaps the gynecologists) more comfortable.

Various forms of delay have also received attention in terms of its strategic value in addressing sexual matters. Delay can include gaps, pauses, fillers, or hesitations in the production of speech. Pomerantz (1984) has shown that interactants employ delays prior to the production of an utterance/response, within an utterance, and within a sequence of actions. Pomerantz argues that delays can function as a method for signaling the production of a dispreferred or problematic turn component. Numerous researchers have built on this claim in analyzing delay in sexual talk (Linell & Bredmar, 1996; Silverman, 1994; Silverman & Bor, 1991; Silverman & Perakyla, 1990; Weijts et al., 1993), arguing that delay can be used to display appropriate circumspection about a delicate term.
Another way to talk about delay is delay within the consultation. Maurice (1998) argues that sexual matters should be delayed until relatively late in the consultation, when rapport and comfort can be established.

Finally, the role of embedded presuppositions has received some attention. Researchers consistently caution against formulating questions in ways that display the presumption of heterosexuality (e.g. asking a female patient if she has a boyfriend) (Andrews, 2000). Silverman & Bor (1991) report that practitioners in HIV clinics routinely inquire about sexual partnerships with formulations like: “Any boyfriends, girlfriends?,” which does not display a presupposition of either heterosexuality or homosexuality. On the other hand, Maurice (1998) describes how practitioners can normalize a potentially sensitive topic by using what Kinsey, Pomeroy, and Martin (1949, as cited in Maurice, 1998) termed a “ubiquity technique,” essentially type of embedded presupposition. For example, rather than asking an anorgasmic patient, “Have you ever masturbated?,” a practitioner might ask, “How old were you when you started masturbating?” By building in the assumption that the patient has masturbated, the patient may be less concerned about disclosing potentially embarrassing information.

**Intervening in sexual conduct**

As with the domain of substance use, practitioners’ interventions into sexual matters typically take the form of advice or recommendations about reducing risky behaviors. There is a paucity of research on how this occurs in general practice settings; virtually all of the research has been done in the context of HIV test counseling. While a few different researchers have examined this context (Kinnell & Maynard, 1996; Silverman & Perakyla, 1992), perhaps the best known volume on the subject is a book by
Silverman (1997) entitled, *Discourses of counseling: HIV counseling as social interaction*. This text presents many of the strategies that HIV counselors employ to advise risk reduction among clients. As with advice regarding substance use, the strategies described here display an orientation to balancing the need to provide adequate education and care with the need to maintain respect and rapport.

A common strategy that HIV test counselors use is to deliver advice tacitly by formulating it as information provision. In doing so, counselors resist the appearance that they are sanctioning patients or directing them about what to do in these highly intimate aspects of their lives. In Silverman’s data, the information-as-advice typically takes the form of reporting the clinic’s stance or perspective on various behaviors, what he describes as “information-about-the-advice-that-would-be-given.” Some examples include: “We would suggest…,” “What we recommend…,” “The recommendation is…,” and “I tell women that come through here…” (p. 177-178). These examples also illustrate another strategic approach taken by counselors, which is to depersonalize advice, treating it as something they offer to all patients, not just this patient. This can serve to reduce the appearance that the patient’s circumstances are uniquely or especially advice-worthy. In other cases, counselors seek to personalize their advice by positioning it as responsive to a patient’s concerns. Even when a patient has not explicitly solicited advice, their surfacing a problem, concern, or confusion allows the counselor to frame his/her advice as a form of ‘help’ that the patient occasioned. Another strategy is to pose leading or hypothetical questions that allow patients to infer an advisable course of action. In one case in his data, a patient was reluctant to start using condoms with her boyfriend because she doesn’t like using them. The counselor asked the patient to imagine that she found
out that her boyfriend was HIV positive and asked, “What do you think if you could have
had that experience again how might things be different do you think?” The patient
responded, “I would have used them.” By asking questions, the counselor essentially co-
implicated the patient in formulating the advisable course of action, which mitigated the
issues tied up in dictating life choices to the patient.

Language and Social Interaction

The other major body of literature that this study draws on is in the area of
language and social interaction (LSI). Researchers in this area tend to be focused on
describing the microstructures of interaction and the cultural knowledge and sense-
making resources that participants draw on to produce meaningful social actions and
activities. In this section, I review three streams of research that are relevant for the
current study. First, I review research on identity and interaction, examining what it
means to study identity from an interactional perspective and also describing some different
types or notions of identity. Next, I review research on ‘delicate’ talk, talk that exhibits
sensitivity to moral or normative concerns. Finally, I review research on the social
actions of information seeking and reporting, the focal activities in this analysis.

Identity and Interaction

The notion of identity has been defined and explored in myriad ways throughout
the social sciences (see Widdicombe, 1998 for a review of demographic, sociological,
anthropological, social psychological, and cognitive psychological treatments). A
distinctive feature of interaction-based research on identity is that it treats identity as a
situated, contingent accomplishment of social actors, something that is claimed, enacted,
negotiated, refuted, defended, etc. in the course of interaction. In summarizing
ethnomethodological or conversation analytic approaches to identity, Antaki and Whiddicombe (1998) offer, “[It is] not that people passively or latently have this or that identity which then causes feelings and actions, but that they work up and work to this or that identity, for themselves and others, there and then, either as an end in itself or towards some other end” (p. 2).

Antaki and Whiddicombe put forth a range of propositions/assumptions that researchers in this area bring to the study of identity. These propositions significantly inform the analytic approach of this study, particularly the first proposition, which speaks to the significance of categorization: “For a person to have an identity – whether he or she is the person speaking, being spoken to, or being spoken about – is to be cast into a category with associated characteristics or features” (p. 3). Drawing on Sacks’s (1992) work on membership categorization devices, this proposition frames identity in terms of incumbency in a social category (e.g. extrovert, boy, pilot, African American, friend, etc.). Categories are associated culturally with specific sets of characteristics, what Sacks has termed “category-bound features,” or “category-bound activities” (e.g. a pilot is a category of person who flies aircraft). Importantly, categories and category-bound features are mutually implicative. Claiming membership in a category implies one’s possession of category bound features. Likewise, claiming or displaying category-bound features can imply one’s membership in a category. For example, physicians may avoid using a category term such as ‘alcoholic’ in discussions with patients (Thom & Tellez, 1986), as this could imply normatively undesirable category-bound features/activities, such as uncontrolled drinking, poor self-discipline, untrustworthiness, moral weakness, etc. At the same time, patients may minimize or underreport their alcohol consumption
(Rapley et al., 2006) because descriptions of heavier drinking could constitute an inference-rich, category-bound feature of a normatively undesirable category, like ‘alcoholic.’

Zimmerman (1998) proposes some useful distinctions between three types of identity that are relevant in interaction-based research. A discourse identity is a function of the social actions and activities a person produces in the moment-by-moment flow of interaction: current speaker, information seeker, advice giver, troubles recipient, interrupter, storyteller, etc. The enactment of a discourse identity has implications for the discourse identities that become available to co-participants. Enacting the role of storyteller occasions and invites co-participants’ enactment of a reciprocal discourse identity: story recipient. In the course of everyday interaction, discourse identities are typically in constant flux. This is less true in institutional interaction, where the accomplishment of institutional goals may require participants to maintain relatively stable discourse identities. History taking is a convenient example. During history taking, physicians generally enact the discourse identity of information seeker and patients generally enact the reciprocal discourse identity of information provider, or reporter.

A situated identity is essentially a social role, a person category that is relevant for some larger situational context: physician, patient, confidante, mother, employee, host, etc. As with discourse identities, the enactment of a situated identity has implications for the identity enactments that become available to co-participants. Often, situated identities are enacted in reciprocal “identity sets” (p. 90) such as physician-patient or parent-child, where the coherence of one enactment depends upon the other. It should be noted that the accomplishment of situated identities typically requires coordination and alignment at the
level of associated discourse identities. For example, physicians’ and patients’ realization of their situated identities as physician and patient requires some alignment regarding the discourse identities of information seeker and reporter. While patients can and do seek certain kinds of information from physicians, it would be incommensurate with the patient role to, for example, conduct a thorough medical history of one’s physician.

Zimmerman uses the term *transportable identity* to refer to aspects of identity that, “travel with individuals across situations” (p. 90). This generally includes all outwardly visible identity categories, such as gender, race, and age. Zimmerman argues that these aspects of identity can emerge as relevant in any interaction or in any situation, but that they should be viewed empirically as latent, essentially ‘tagging along’ with a person. He offers a critical distinction between *apprehension* (or awareness) of a transportable identity and *orientation* to that identity in interaction. Social actors may apprehend that a person carries the outwardly visible, transportable identity of ‘woman’ without orienting to that category as relevant for conducting the interactional business at hand. But, as with discourse identities and situated identities, there are interactional resources through which social actors can implicitly and explicitly invoke the relevance of transportable identities (e.g. “Well, speaking as a woman…”).

Ethnomethodological and conversation analytic approaches to identity are significantly informed by the sociological theory of Erving Goffman (1955; 1959; 1963; 1967; 1971). Goffman’s dramaturgical perspective employs a theatrical metaphor, conceptualizing social interaction essentially as a stage play, where interactants work to competently enact their chosen (or situationally assigned) parts in order to maintain an orderly and coherent production. This perspective is fundamentally interactional; it
illuminates the ways in which social actors rely upon their shared cultural knowledge and practices to collaboratively realize everyday social activities and to negotiate appropriate role identities within those activities. In this section, I describe some more specific aspects of Goffman’s work on identity and interaction, showing how they inform the analysis of physician-patient interaction regarding lifestyle. I also extend one aspect of Goffman’s work to propose a fourth type of identity that may be added to Zimmerman’s discourse, situated, and transportable identities.

As a whole, Goffman’s work on identity resonates most closely with what Zimmerman terms situated identity, an identity category whose relevance is tied to a situational context (e.g. a person can become ‘a patient’ during a medical visit). Goffman refers to situated identities in terms of roles or role identities. The enactment of any role is a contingent accomplishment, one that, like a theatrical production, can be judged to be more or less competent. Goffman’s notion of ‘face’ (1955) refers to an actor’s perceived competence in projecting his or her credible incumbency in a chosen role. Information or actions that have the potential to undermine the credibility of the actor’s performance are described as ‘face threats’ and can result in a loss of face. When face is threatened, social actors may engage in ‘face-work’ in order to protect and restore a claimed identity, essentially saving face. Face-work is a form of identity management, an effort to project, protect and/or restore the legitimacy of a claimed role through within one’s local interactional performance.

Goffman’s concept of a “virtual offense” (1971) provides a compelling way to link the notion of problematic conduct with identity inferences and subsequent remedial work:
“In order to understand remedial work, I think it is useful to assume that the actor and those who witness him can imagine (and have some agreement regarding) one or more “worst possible readings,” that is, interpretations of the act that maximize either its offensiveness to others or its defaming implications for the actor himself. This ugliest possible significance I shall call the “virtual offense.” This name is selected because the remedial activity that follows a possibly offensive act very often can be understood best by assuming that the actor has these worst possible readings in mind as that to which he must respond to and manage” (p. 108-109).

A particularly useful part of this description is the idea of “worst possible readings” of an act. Goffman locates problematicity (i.e. “offensiveness”) not as an inherent feature of the act itself, but in the social sense that may be made of the act, particularly its “defaming implications” for the actor. The problem with face-threatening information is not necessarily in the information itself, but in the possibility that the information could be understood as typical or emblematic of the actor.

In Stigma: Notes on the management of spoiled identity (1963), Goffman introduces some other aspects of identity management that I draw on in this analysis. This text is primarily concerned with the social and interactional dilemmas that stigmatized individuals face in negotiating their identities in the company of ‘normals.’

1 Written in 1963, this text reflects certain predominant cultural understandings of the times. As such, some of Goffman’s ideas and illustrations may seem politically incorrect or offensive to modern readers, particularly the kinds of characteristics that may qualify one as stigmatized (e.g. “physically deformed people” or “urban lower class Negroes”). My sense is that Goffman was interested in the sociological and interactional phenomena involved in managing ‘problematic’ identities; he was not interested in the politics of legitimizing or challenging what should rightly count as a stigma. In any event, although
Goffman makes a distinction between a discredited identity and a discreditable identity.

In the case of a discredited identity, a person carries an outward “stigma symbol” that discredits him or her simply by virtue of its visibility. For example, a person with a facial deformity bears a discredited identity. In the case of a discreditable identity, the characteristics that would provide a basis for stigmatization are not outwardly visible. Rather, stigmatization is a potentiality, contingent on the surfacing of discrediting information. For example, an ex-mental patient may work to prevent this information from coming out in interaction with others. When one’s identity is not discredited, but is discreditable, identity management is primarily a matter of information management. In effect, this means carefully controlling who gets to know what about one’s history.

Most relevant for the activity of lifestyle history taking is the concept of discreditable identity, in that the information that patients provide about their conduct has the potential to “spoil” their identity. Patients face a special dilemma in managing potentially discrediting information during lifestyle history taking. On one hand, they may be motivated to disclose accurate and complete information in order to ensure that their physicians are able to provide appropriate medical care. On the other hand, they may be motivated to withhold some medically relevant information, such as past use of intravenous drugs, because of the potential identity implications. By virtue of these countervailing motives, information management may become a particularly complex matter in lifestyle domains. A patient cannot simply ‘hide’ all discrediting information without risking consequences for his/her health care.

the particular characteristics that provide a basis for stigma may be culturally and temporally variable, Goffman’s primary contribution lies in the theoretical claims he made about how stigma is managed socially.
Goffman’s dramaturgical perspective (1955; 1959) also emphasizes that social interaction is a collaborative production, where each actor’s performance, including their role enactment, is interwoven into the performances of others. Thus, claiming or sustaining an identity is not the unilateral accomplishment of a single actor, but rather relies upon the mutual coordination of all actors in the ‘scene’ to sustain a shared definition of the situation and their respective roles within it (“expressive order” in Goffman’s (1955) terms). The enactment of the roles ‘physician’ and ‘patient’ are thus collaborative performances, where each actor’s performance can have consequences for the other actor. Just as actors can intentionally or unintentionally threaten one another actor’s face, they can also ‘give face,’ a form of face-work undertaken by one actor to affirm or restore another actor’s performance. Ultimately, the management of available identities is always a joint venture of the actors involved.

As noted, Goffman’s notion of role enactment resonates most closely with Zimmerman’s notion of situated identity, an identity that is relevant and available within a particular situational context. The same actor may claim a range of situated identities in the course of a single day or even a single interaction, each one selected based on its situational relevance (e.g. the same actor may be laywer, diner, Mom, etc.). Different role identities call upon different performative resources within an actor and require the projection of different personal qualities, different versions of self. For the most part, Goffman treats selfhood as ephemeral, bound up in temporary and ever-shifting role requirements. One exception is in his discussion of “character” from the essay, Where the action is (1967). Character, he argues, is understood to be a stable and enduring aspect of
the self, something fundamental about the actor that can be revealed behind the situated, fragmentary versions of self made visible through situated roles.

Character is fundamentally a moral concept, premised on a broadly shared orientation to socially desirable and undesirable activities or characteristics. Like any other aspect of identity, judgments about character are informed by culture. Goffman argues that character has many dimensions: **courage**, the ability to proceed in the face of danger; **gameness**, the ability to persevere despite setbacks; **integrity** (or self-discipline), the ability to resist temptation; **gallantry**, the ability to maintain forms of courtesy in difficult circumstances; **composure**, the ability to maintain poise under pressure. Character essentially involves culturally idealized qualities of personhood, qualities whose value is largely independent of any particular role enactment. For example, Goffman observes that, even though ‘bank robber’ may be an undesirable social category, a bank robber may be admired for the courage and composure that is required for, and revealed in, his activities. Although Goffman developed his notion of character primarily to describe occupants of such ‘risky’ social roles (e.g. gamblers, criminals, stock speculators, soldiers, etc.), he also argues that everyday life presents everyone with “character contests” (p. 239), social moments in which our fundamental character becomes visible and evaluable. Even though character is revealed only in and through these situated moments of interaction, character itself is understood to be a stable, permanent feature of the actor. Goffman explains:

“And now we begin to see character for what it is. On the one hand, it refers to what is essential and unchanging about the individual – what is characteristic of him. On the other, it refers to attributes that can be generated and destroyed
during fateful moments. In this latter view, the individual can act so as to
determine the traits that will thereafter be his; he can also act so as to create and
establish what is to be imputed to him. Every time a moment occurs, its
participants will therefore find themselves with another chance to make
something of themselves. (p. 238, italics in original).

Goffman argues that there is an overarching, trans-situational cultural value
placed on the projection of “strong” character (p. 217) and that this serves larger
structural-functional purposes: “Possibilities regarding character encourage us to renew
our efforts at every moment of society’s activity we approach, especially its social
ones…We are allowed to think there is something to be won in the moments we face so
that society can face moments and defeat them” (p. 239). What is at stake in character
contests, or any revelation of character, is one’s fundamental orientation to prevailing
cultural values.

Goffman’s notion of character can be understood as an additional type or
dimension of identity, along with Zimmerman’s notions of discourse, situated, and
transportable identity. In working to reveal or project strong character, an actor
effectively makes claims to being in the category, ‘good person,’ a morally sound,
normatively appropriate cultural member. Character provides a useful conceptual
framework for understanding this order of identity work, work that is directed toward
achieving an identity that is desirable above and beyond one’s local discursive or
situational requirements. Thus, displaying strong character may be a desirable projection
of self whether one is in the role of information seeker/reporter (discourse identities),
physician/patient (situated identities), or male/female (transportable identities). Because
character speaks to fundamentally moral concerns, it is also well suited to examining subject matters that are understood to have moral implications, such as substance use and sexual conduct.

A common thread in Goffman’s work and in ethnomethodological and conversation analytic work on identity is the notion that identities are made relevant contingently, in and through interaction. This applies to discourse identities, situated identities, transportable identities, and character. Because interaction is spontaneous, collaborative, and complex, one can never pre-specify or fully control the identities that emerge as relevant for the business at hand. While this could be said for any social actors in any social circumstance, I would argue that it poses special challenges for incumbents of the patient role.

As previously noted, the patient role can be understood as a situated role identity, one that is relevant for participating in medical consultations. Incumbents of the patient role may well be evaluated for their competence in fulfilling that role, which involves a range of performance expectations (e.g. show up on time, present or describe a symptom or complaint, ask questions, report information, accept physical examination, consider treatments, etc.). Often enough, enacting the patient role requires persons to report on their conduct outside of the medical setting, when they are not acting in the role of patient. This feature of the patient role -- the recurrent requirement to report on everyday experiences and activities -- creates unpredictable glimpses into one’s activities when one is not an incumbent of the patient role. Persons may be rightly concerned to manage what is made of this information even as they are managing the active, local demands of the situated patient role. ‘Lifestyle’ domains are especially sensitive in this regard, as they
may threaten to reveal normatively problematic performances and identities (e.g. alcoholic, drug addict, unfaithful partner, promiscuous person). This sensitivity may also show up in efforts to portray normatively desirable performances and identities (e.g. social drinker, non-smoker, condom user, monogamous partner, etc.).

**Delicate Talk**

This study draws on and contributes to a body of literature on ‘delicate talk.’ As Bergmann (1998) notes, in matters that involve moral or normative evaluations, persons often display caution or circumspection in their talk. In this section, I describe the notion of conversational delicacy and draw out some themes and complexities that run through this literature. Clearly stated conceptual definitions of conversational delicacy are rare, though Linell and Bredmar (1996) provide one that builds out of some recurrent themes in the literature. They define a delicate matter as one that “cannot be addressed directly or explicitly by the speaker without endangering the interactional harmony of the encounter by threatening the listener’s face and therefore also the speaker’s own face” (p. 347-348). Three aspects of this definition are worth underscoring.

First, Linell and Bredmar’s definition underscores a persistent connection in the literature between delicacy and indirectness (Drew, 1984; 1998; Jefferson, 1987; Maynard, 1998; Pomerantz, 1980; 1984). A common thread in most analyses is that indirectness is a powerful resource for displaying or proposing the delicacy of some matter. When speakers produce talk that is indirect, it may be in an effort to remain “off-record” (Brown & Levinson, 1987), reducing the speaker’s accountability for having done the very thing that was elided by the indirect formulation. Thus, indirect or implicit
formulations provide a resource for pursuing a potentially delicate matter with displayed circumspection.

Second, Linell and Bredmar’s definition of delicacy clearly draws heavily on Goffman’s notion of face (1956; 1959) and, in particular, on his norms of self-respect and considerateness, which suggest that social actors are motivated to preserve their own faces and others’ faces in order to maintain the “interactional harmony” of the encounter. The implication here is that a failure to properly anticipate the delicacy necessary for pursuing some matter will threaten to undermine the competent enactment of elected or assigned roles and, by extension, will threaten to undermine expressive order. One important feature of this conceptualization is that delicacy is displayed in order to protect against various kinds of unwanted interactional consequences and, perhaps in some cases, against untoward social attributions.

Finally, Linell and Bredmar’s definition suggests that a failure to display delicacy in a situation for which delicacy may be expected is mutually face threatening. A lack of delicacy is not just problematic for the author of a gaffe; it also implicates co-present others who must respond in some way to an unanticipated and potentially problematic interactional contingency. The logical extension of this claim is that it is doubtful that any social actor could independently define or unilaterally preserve the degree of interactional delicacy required in a given scene. Rather, social actors collaborate in creating and maintaining a mutual orientation to the kind of delicacy required (or not) in the scene because lapses in this feature of the local expressive order will necessarily be mutually consequential for both parties.
I offer four additional observations about the available literature on delicate talk. The first observation deals with the distinction between delicate social actions and delicate topics, a distinction that may sometimes be obscured by the broader label of delicate talk. The next two observations address the importance of context (cultural and situational) in the study of delicacy. The final observation builds out of these concerns for the role of context and provides a modest solution for thinking about delicacy in conversation.

The study of delicate talk has been approached in two ways. One way has been to examine talk in delicate topical domains. Another way has been to examine talk in the environment of delicate social actions. Both approaches are relevant for this study and the distinction is important. By ‘topical domain,’ I mean to refer simply to a subject matter. As noted previously, much of the research on substance use and sexuality operates from the premise that these are delicate topical domains and that the talk in these domains exhibits sensitivity to that delicacy (e.g. Satterlund Larsson et al., 1987; Weijts et al., 1993). A ‘social action’ is essentially a unit of social or conversational activity, such as seeking information, reporting, agreeing, etc (see Pomerantz & Fehr, 1997 for more on social action). Numerous social actions have been analyzed as potentially delicate: inviting (Drew, 1984), correcting (Harness Goodwin, 1983; Jefferson, 1983), teasing, (Drew, 1987), disagreeing (Kotthoff, 1993; Pomerantz, 1984), complaining (Drew, 1998), advising (Goldsmith & Fitch, 1997; Heritage & Sefi, 1992; Jefferson & Lee, 1992) and others. Much of this research examines how the delicacy of the action is constituted and how interactants work to avoid or interactionally adapt to its delicacy.
As I argue in more detail below, the extent to which interactants orient to any topical domain or social action as delicate is powerfully shaped by context. For example, the topical domain of sexuality may be non-delicate for friends, but delicate for parents and children. Likewise, the social action of correcting may be non-delicate for parents and young children, but delicate for friends. It may also be said that some activities involve simultaneously delicate actions and topics, such as when a physician advises (delicate action) a patient about practicing safe sex (delicate topic). In such cases, each source of delicacy may contribute to the quality of the talk.

The second observation concerns cultural context. If we grant the premise that culture shapes what members come to see as delicate (Bergmann, 1992), then there can be no guarantee that persons from different cultural orientations will view the same matter as similarly delicate. From an empirical perspective, one cannot presume correspondence between the cultural and moral perspectives of the analyst who describes a matter as delicate and the perspectives of the observed social actors who are actually dealing with the matter thus described. One can see with very little effort that what is considered a delicate matter for some social actors is perfectly comfortable for others. Cultural routines, expectations, mores, and taboos vary greatly and any analyst’s situated understanding of some matter as delicate may not obtain beyond his or her cultural community. Thus, relying on native intuitions alone to label some matter as intrinsically delicate and then operating with this as an analytic starting point is problematic.

The third observation concerns situational context. Even among those who share a similar cultural orientation, the abstract, de-contextualized conceptualization of some matter as intrinsically delicate creates the impression that all talk on that matter will
necessarily reflect this delicacy. It assumes that orienting to a particular matter requires delicacy on the part of interlocutors, regardless of their claimed social identities or the social environment in which they are communicating. The delicacy with which some topic is pursued or some action is performed may be powerfully shaped by the role relationships (e.g. wife/husband v. physician/patient) and the social activities (e.g. gossip v. medical history taking) through which the talk is constituted. Treating delicacy as an objective, immutable feature of an action or topic obscures attention to the contribution of the practical social contexts (roles, activities, settings, etc.) in which that matter is occasioned.

My final observation deals with the potentially reflexive character of conversational delicacy. Some conceptualizations of conversational delicacy treat the proposedly known-in-common delicacy of a given action or topic as an antecedent condition that contributes something to the ways in which talk about that topic is subsequently formulated. Given this orientation, delicate talk could be analyzed as manifestations of interlocutors’ cognitive orientations to those matters. However, this is not the only option. As some ethnomethodologists and conversation analysts have argued, the delicacy of some matter may actually be reflexively constituted and negotiated through the manner in which social actors orient to it within situated moments of interaction (Bergmann, 1992; Silverman, 1994; Weijts et al., 1993). Implicit or indirect formulations, for instance, may be understood as a speaker’s resource for proposing the delicacy of some matter at the very moment of its production. These formulations may further serve as recipients’ criteria for recognizing that such a proposal has been made. Rather than viewing delicacy as a psychological or cognitive antecedent
of communicative choices, delicacy can be viewed as an interactional achievement, constituted through the organized ways in which social beings orient to some matter. It may then be said that delicacy is not an inherent feature of a given action or topic but rather that the delicacy of any object is achieved here and now through the demonstrable work of social actors to treat it that way (or not). As Bergmann (1992) has argued:

“By describing something with caution and discretion, this ‘something’ is turned into a matter which is in need of being formulated cautiously and discreetly. Viewed sociologically, there is not first an embarrassing, delicate, morally dubious event or improper behavior about which people then speak with caution and discretion; instead, the delicate and notorious character of an event is constituted by the very act of talking about it cautiously and discreetly” (p. 154).

While this perspective on conversational delicacy is important for ethnomethodological or conversation analytic approaches, in my view it would be an overstatement to argue that social actors rely only on emergently available interactional cues in orienting to some matter as delicate. Social life is, of course, not invented anew each time two social beings come into contact with one another. Culture itself provides members with reasonably stable knowledge and understandings, resources that must be drawn upon to produce an intelligible social order (Fitch, 1998; Hymes, 1974; Moerman, 1993; Sanders, 1998). Some of that knowledge speaks to what is recognizably delicate within a cultural context. Societal taboos, for example, are understood as delicate in an almost primordial (and certainly pre-interactional) way.

There is at least one way to reconcile a view of delicacy as emergent and interactional with a view that appreciates the stable, enduring cultural knowledge that
undergirds it. This involves treating cultural knowledge about what is delicate as an interactionally realizeable potentiality. For instance, social actors may elect to treat potentially or customarily delicate matters as actually delicate within a situated moment of interaction and, in so doing, may be understood as proposing the applicability of known-in-common cultural understandings in that moment. Or social actors may elect to treat potentially or customarily delicate matters as not delicate and, in so doing, may be understood as proposing that something about the social environment (e.g. the setting or the actors’ relationship) warrants the development of non-delicate talk about a customarily delicate matter. In either case, social actors can be seen as coordinating and negotiating the relevance of their shared cultural understandings as they jointly produce and reproduce a coherent social order.

Research on Information Seeking and Reporting

This study draws on and contributes to research on information seeking and reporting. These are conceptualized as complementary social actions, realized collaboratively through the interweaving and conditionally relevant contributions of multiple social actors. In this section, I review research on two main topics: 1) key conceptual issues/complexities; 2) examples of interactional practices for performing the activity.

Key Conceptual Issues/Complexities.

There is an important conceptual distinction to be drawn between ‘questions and answers’ -- the commonsense terms we might use to talk about the exchange of information -- and information seeking/reporting. As the literature in this area has demonstrated, not all instances of information seeking/reporting involve questions and
answers and not all instances of questions and answers are about information exchange. A simple way to appreciate the distinction is to see a ‘question’ as a syntactic object and to see ‘information seeking’ as a social action. While it is true that a ‘question’ can and often does perform the social action of seeking information, the distinction between syntactic form and social function is empirically significant.

As noted, an utterance can perform the social action of seeking information without including overt syntactic question forms such as interrogative pronouns (who, what, when, etc.) or subject-verb inversion (‘Is John there?’). For example, rising intonation at the end of a declarative utterance – a phonological rather than syntactic cue -- is commonly understood to be seeking information (or at least confirmation) relative to what has been declared (e.g. ‘We’re going to the mall?’). Because a great deal of the meaning ascribed to utterances is a function of the larger social activities into which those utterances are embedded (Garfinkel, 1967; Levinson, 1992; Turner, 1970), the activities themselves can become interpretive resources for recognizing a wide range of utterances as seeking information. For instance, Satterlund Larsson, Saljo, and Aronsson (1987) show that, when embedded within the framework of a medical interview, an utterance such as “And alcohol.” can be understood as seeking information about alcohol consumption even though this is not the formal syntax or intonation associated with questions.

Just as information exchange may be accomplished without the use of questions and answers, questions and answers are not always about information exchange. Levinson (1992) describes two settings in which questions and answers are recurrently deployed without information exchange as a central goal. During cross-examination of
witnesses, he argues, both the attorney and the witness have access to the same
information (usually included within affidavits and other court documents). Nonetheless,
attorneys use questions to direct the witness to provide particular pieces of information.
Because every answer is already known by the attorney, cross-examination isn’t really
about information exchange. Rather, Levinson argues that this is about building an
argument, where the questions are structured in such a way that the answers provided by
the witness constitute a specific and slanted rendering of the facts. A second setting
described by Levinson is a classroom setting, where instructors use questions not for the
purpose of information seeking, but to ‘quiz’ students on their command of class
materials. Instructors position themselves as in possession of the requested information,
but use questions that direct students to provide answers that will demonstrate their
possession of that information as well.

These examples illustrate the usefulness of distinguishing between syntactic form
and social function in analyzing processes of information exchange. Although researchers
in this area will sometimes use the familiar and parsimonious language of ‘question’ and
‘answer’ to make observations in intuitive ways, the appeal of the terms ‘information
seeking’ and ‘reporting’ is that they provide a way of capturing a particular kind of social
action without wedding it to the logic or structure of a syntactic object (a question) that
functions as just one method out of many used to accomplish that action.

Examples of Interactional Practices For Performing the Activity.

A central goal for conversation analytic work in this area has been identifying and
describing the practices that interactants use to seek and provide information. A core
assumption in this work is that the ways in which these activities are designed powerfully
shapes the local sense that is made of them. It is beyond the scope of this project to review all of the literature in this area. In this sub-section, I review two practices identified by Pomerantz that serve as exemplars of work in this area. Along with the work cited by Levinson (1992) above (on cross examination and quizzing), these practices also illustrate the potential multifunctionality of information seeking and reporting utterances, that is, the range of other social actions that these utterances can accomplish.

One information-seeking practice identified by Pomerantz (1980) is what she calls a “my side” telling. In formulating a “my side” telling, a speaker asserts his/her recognizably incomplete knowledge of some matter. Recipients of “my side” tellings are positioned as having full (or better) knowledge of that matter, often because they are a principle agent and would likely know the ‘missing’ information. “My side” tellings provide an opportunity for the recipient to fill in that information. The following excerpt from Pomerantz (p.189) illustrates this phenomenon:

[NB: II:2.-1 simplified]

A: Your line’s been busy
B: Yeah, my father’s wife called me

“My side” tellings function as a way to elicit information from others without directly asking for that information. Although recipients of “my side” tellings do frequently elect to provide the missing information, they may also elect not to provide any additional information and instead treat the telling merely as a casual informing. Though such a response may be seen as withholding, it is, Pomerantz argues, no more accountable as a withholding than the “my side” telling is accountable as information seeking. Both actions are performed in an off-record manner. As such, “my side” tellings
may provide a resource for eliciting information when direct questions would be presumptuous, insensitive, etc.

Another information-seeking practice identified by Pomerantz (1988) involves the inclusion of a “candidate answer” as part of an inquiry. Pomerantz argues that, in providing responses to inquiries, interlocutors do not just provide what is literally asked for. Rather, in deciding what to provide as a response, they actively analyze what may be motivating the inquiry. A candidate answer functions as a guide for recipients engaged in this kind of analysis by modeling the type of response that would satisfy the information seeker’s purpose. The following excerpt from Pomerantz (p. 368), a telephone interaction between a high school attendance clerk and the mother of an absent student, illustrates this phenomenon:

[Med.5 simplified]

Clerk: Was Arthur home from school ill today?

Mother: No he wasn’t

((several lines omitted))

Mother: Oh wait a minute

Clerk: Okay

Mother: He had a doctor’s appointment. That’s right.

Rather than asking “Why wasn’t Arthur in school today?” the clerk provided the candidate answer “home from school ill” as part of the inquiry, which could then be confirmed or denied by the mother. By providing such a candidate answer, Pomerantz argues, the attendance clerk was guiding the mother to see that the purpose of the inquiry is to determine if the student’s absence is legitimate or not. Although the mother had
already technically answered the clerk’s initial inquiry, her subsequent report that Arthur had seen the doctor was responsive to the inferred purpose of the inquiry. Additionally, Pomerantz argues that when interlocutors provide a candidate answer, the candidate answer often represents what could be seen as a legitimate or acceptable state of affairs, though this may be influenced by the norms of politeness that obtain in a given activity context. In the extract above, “home from school ill” is a legitimate reason to be home from school. Thus, a candidate answer can display the speaker’s expectations about the matters inquired about and, through this, his or her evaluations of those matters.

Particularly relevant for this present study is the fact that each of these practices for seeking information exhibits some sensitivity toward normative or moral concerns. “My side” tellings can be seen as a resource for displaying an appropriate stance toward one’s entitlement to know something about someone else. This method does not ‘demand’ an answer in the ways that direct questions can, and thus displays some respect for the recipient’s control over the information. Candidate answers can display an evaluative stance, where one’s ‘best guess’ about the matters inquired about can be seen to reflect the speaker’s expectations toward those matters. When speakers employ legitimizing candidate answers, they display a positive expectation. While we often think of questions as eliciting information, revelations, or disclosures from another party, these practices show that questioning is potentially revelatory for the information seeker as well.
METHODOLOGY

Setting

All data for this project were collected at a family practice group associated with a teaching hospital in upstate New York. This practice had approximately 26,000 visits during 2002, the most recent year for which data were available. This setting presented three advantages for this study.

First, the practice serves a wide range of patients, from middle-class suburban state workers to indigent inner-city residents. Among the patients, approximately 15% are on Medicaid, 10% are on Medicare, and 25% are from designated medically underserved areas of the surrounding city. The setting presented a relatively diverse population from which to draw patient participation.

Second, among medical specializations, family medicine is especially committed to providing care that is sensitive to the psychosocial dimensions of health and illness (Fujikawa, Bass & Shneiderman, 1979; Murata, 1993; Murphy & Mattson, 1992; Stange, Jaen, Flocke, Miller, Crabtree & Zyzanski, 1998; Stange, Miller & McWhinney, 2001). This essentially means that family physicians attend not only to the biomedical aspects of patients’ health, but also to patients’ overall psychological well being and the social/relational contexts in which health and illness is experienced. It is considered standard practice for family physicians to address substance use and sexual activities while taking a general medical history, as these domains fall well within the specialization’s focus on patients’ psychological and social/relational health. This setting was no exception. For example, as part of their training, family practice residents at this
site attended seminars on substance use and sexual history taking (though no residents participated in this study).

Third, family practice represents a novel setting in which to examine sexual health discussions. Most of the work in this area has been based in gynecological settings (Emerson, 1970; Weijts, 1993) or in HIV test counseling sessions (Perakyla & Bor, 1990; Silverman & Perakyla, 1990, Silverman & Bor, 1991; Silverman, 1994). In both of these settings, talk about sexual activity is anticipated (and to a certain extent foregrounded) as a central aspect of the medical services provided. By examining a general practice setting, we can see how sexual matters are raised and attended to as one component of a larger medical history. Additionally, family practice settings involve a continuity of care that would not be expected in HIV test counseling sessions, where the provider-patient relationship is, by definition, temporary. Different issues may be relevant when patients discuss substance use and sexual health with providers with whom they may have an ongoing therapeutic relationship.

Participants

There were two categories of participants in this project, physicians and patients. In this subsection, I describe the selection criteria, consent procedures, and basic demographics of all participants in this study. It should be noted that the principal investigator (PI) obtained a certificate of confidentiality from the National Institute of Health in order to protect all data from subpoena.

Physicians

Six physicians participated in this study, all of whom self selected to participate. Their involvement was facilitated by a faculty member in the department of family
medicine, who served as an informal liaison between the PI and the family practice prior to data collection. This liaison circulated a solicitation letter from the PI among the physicians at the practice and those who were interested contacted the liaison. The PI then met with interested physicians at the family practice to discuss the project and the consent procedures for both physicians and patients.

Physician participation was voluntary and no monetary incentive was offered. The PI explained all confidentiality procedures to participating physicians, including the protections of the certificate of confidentiality. Physicians were fully aware that the study involved video recording their consultations with patients (explained in further detail in the data collection subsection). Physicians were told that the purpose of the study was to examine communication processes between physicians and patients during routine (comprehensive) medical history taking. In order to minimize reactivity effects, they were not told of the topical foci on substance use and sexual activities.

Demographic data for the physicians were collected informally and with less precision than for patients. No substantive claims are made in the analysis regarding the demographic features of any participants. Table 1 summarizes the demographics of the physicians.

Table 1

<table>
<thead>
<tr>
<th>Physician</th>
<th>Gender</th>
<th>Age (approximate)</th>
<th>Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td>female</td>
<td>30</td>
<td>Middle Eastern</td>
</tr>
<tr>
<td>Dr. F</td>
<td>male</td>
<td>40</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Dr. K</td>
<td>female</td>
<td>40</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Dr. M</td>
<td>male</td>
<td>60</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Dr. P</td>
<td>female</td>
<td>30</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Dr. R</td>
<td>male</td>
<td>30</td>
<td>Caucasian</td>
</tr>
</tbody>
</table>
Different physicians completed different numbers of video recordings. Various practical factors bore on this outcome. For example, Dr. M was a senior physician and was transitioning away from seeing patients on a regular basis. Two other physicians (Dr. K and Dr. P) left the practice for other positions during the period of data collection. Taken together, the six physicians completed 24 video recordings. The distribution of these recordings is presented in Table 2.

Table 2

<table>
<thead>
<tr>
<th>Physician</th>
<th># of video recordings completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td>9</td>
</tr>
<tr>
<td>Dr. F</td>
<td>4</td>
</tr>
<tr>
<td>Dr. K</td>
<td>2</td>
</tr>
<tr>
<td>Dr. M</td>
<td>1</td>
</tr>
<tr>
<td>Dr. P</td>
<td>1</td>
</tr>
<tr>
<td>Dr. R</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>N = 24</td>
</tr>
</tbody>
</table>

Patients

Of the 55 patients who were solicited to participate in the study, 24 (44%) consented. There were three selection criteria. First, the patient had to be an adult (18 years or older). Second, the patient had to be scheduled to meet with one of the six participating physicians. Third, the patient had to be scheduled for a comprehensive history and physical for that day’s visit. At the site, this was referred to as an “H&P” (history and physical). There were two types of patients who were scheduled for an H&P: those who needed an annual checkup and those who were new to the practice. Both are routine occasions for performing an H&P across various medical settings.

The decision to select only patients who were scheduled for an H&P had both conceptual and practical bases. On conceptual grounds, almost no research has examined how substance use and sexual activities are discussed during routine history taking. This
is an important activity context in terms of preventive health care and ongoing health maintenance. It allows physicians to identify relevant health risks and behaviors and also inform patients before health problems emerge. As noted, previous research on sexual health discussions has focused on HIV test counseling, a context in which the participants may already have reason to suspect a problem. Likewise, research on substance use has tended to focus on patients with serious addiction problems (Wright, 1995; Maisto, Congliaro, McNeil, Kraemer, Conigliaro & Kelley, 2001) or activity contexts in which substance use emerges in relation to other pressing health problems (Maly, 1993). On practical grounds, selecting H&P visits also maximized the likelihood that the physician and patient would discuss the focal topics, as these were included as a matter of routine. It would have been prohibitively difficult to identity patients whose reason for the visit included substance use and sexual issues and, moreover, soliciting them on these grounds likely would have compromised the desired naturalism (and thus, validity) of their conduct.

The procedures for selecting and soliciting patients were considerably more complex than those for physicians. Every few weeks, staff at the family practice supplied the PI with the upcoming schedules of participating physicians. The PI was informed of the days and times when a participating physician was scheduled to see a patient for an H&P. “H&P” was actually the code used within the practice’s record-keeping software under “reason for the visit” and this was what staff used to search the schedule for potential participants. While these patients always received an H&P, it was not uncommon for other matters to be addressed during these same visits (e.g. follow-up on recent medical problems, new acute medical problems, prescription refills, etc.). Thus,
the “H&P” code served as a selection criterion, but not a limitation on what could happen during the visit. On those days when a suitable patient was scheduled, the PI waited in a private office space at the practice. When that patient arrived at the practice and checked in at the front desk, a staff member gave the patient a solicitation letter from the PI that briefly described the project and sought permission to discuss it with the patient in more detail. When a patient indicated to the staff member that they were willing to discuss the project, the staff member alerted the PI, who brought the patient from the waiting room into the private space. At this point, the PI explained the project, solicited questions, and, if the patient indicated willingness to participate, went through the consent procedures.

Patient participation was voluntary and no monetary incentive was offered. Patients were told that the PI had no affiliation with the family practice and that their participation or non-participation would have no bearing on the quality of care they received. The PI explained all confidentiality procedures to participating patients, including the protections of the certificate of confidentiality. Patients were fully aware that the study involved video recording their consultations with their physicians. Patients were told that the purpose of the study was to examine communication processes between physicians and patients during routine (comprehensive) medical history taking. In order to minimize reactivity effects, they were not told of the topical foci on substance use and sexual activities. However, the patient consent forms included a list of the topics that are routinely addressed during a comprehensive history, including substance use and sexual activity. No patients who were formally solicited in the private space declined to

2 Scheduled patients who did not actually come to the practice (i.e. “no shows”) were not included in any counts. This was more common than anticipated.
participate at that point. In effect, any patient who indicated an initial willingness to meet with the PI also consented to participate. As part of the consent process, patients were given a “post-visit consent withdrawal” form in a stamped envelope addressed to the PI. The purpose of the form was to allow patients to withdraw their consent for up to two weeks after the consultation. The PI filled in an anonymous code on each consent withdrawal form so that the appropriate data could be destroyed. No patients actually withdrew their consent in this way.

Each patient completed an oral demographic questionnaire at the conclusion of the consent process. The questionnaire included gender, age, and race/ethnicity. Additional details about the questionnaire are provided in the subsection on data collection. Table 3 provides a summary of this demographic information.

Table 3

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
</tr>
</tbody>
</table>

| Age             | Mean = 52 | Range = 25-87 |

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>15</td>
</tr>
<tr>
<td>African American</td>
<td>7</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
</tr>
<tr>
<td>Asian American</td>
<td>1</td>
</tr>
</tbody>
</table>

Procedures

Data Collection

All data were collected by the PI. Data collection took place from September of 2006 through August of 2007 and included a total of 30 days/sessions at the family practice site. There were two forms of data collected. The primary form of data consisted of video recordings of physician-patient interaction during routine office visits. The other form of data consisted of an oral demographic questionnaire administered to patients.
prior to recording their consultations with their physicians. In this subsection, I discuss some of the procedures and issues involved in each form of data collection.

**Video Recording**

Because the family practice is associated with a teaching hospital, one of the examination rooms had already been fitted with a digital video camera prior to data collection. Family medicine faculty members use this room as a teaching tool for residents, providing feedback on their communication with patients. The PI routed the digital signal from the camera into another digital camera in an adjacent closet, the latter camera essentially functioning as a recording device. The practice’s camera had been mounted in one corner of the ceiling, with all wires running into the wall behind it. Although all participants knew they were being recorded, the discrete placement of the camera likely reduced some of the reactivity effects associated with direct observation.

There were two timing issues associated with the video recording. The first was when to actually begin recording the signal from the exam room. Once a consented patient was placed inside the designated exam room, the PI was positioned just outside this room. The physician alerted the PI just as s/he was about to enter. This ensured that the patient was not being recorded when s/he was changing clothes, as was sometimes the case in these visits. The second timing issue was related to the physical examination component of the H&P. Because physical examinations often require partial nudity and/or sensitive and invasive procedures, the video portion of the recording was to be disabled during this portion of the visit. The audio component, however, recorded continuously throughout the visit. During the consultation, the PI remained just outside the exam room; the physician stepped outside briefly to alert the PI when s/he was about
to examine the patient. At this point, the PI removed the video cable from the recording camera, leaving the video ‘black’ (i.e. without signal) but the audio unaffected.

**Demographic Questionnaire**

Just after the consent procedures were completed, the PI administered a brief oral demographic questionnaire for each patient. The questionnaire consisted of four questions: 1) age; 2) gender; 3) race/ethnicity; 4) approximate duration of relationship with the physician. For the race/ethnicity question, rather than asking the patient to select from a prescribed list of categories, which can sometimes cause confusion or misgivings (O’Hara, Shue, Marini, McKenzie, Flanagan & Daniel, 2009), the PI phrased the question as follows: How would you describe yourself racially or ethnically? The primary purpose of the question regarding duration of the relationship with the physician was to identify initial meetings between physician-patient dyads. Thus, although the PI did not (and, given HIPPA regulations, could not) corroborate patients’ approximations, this question did succeed in identifying initial meetings. Among the 24 consultations, seven were initial office visits with new patients and the remaining were returning patients. Among returning patients, estimates of the duration of the relationship with the physician ranged from one month to eight years.

No substantive claims are made in the analysis regarding the demographic features of any participants. This information was gathered largely for background information and possible future applications.
Data Preparation

All recordings were reviewed for audio and video quality. One recording contained a severe audio defect that rendered the talk virtually unintelligible. This case was removed from the analysis, leaving the total corpus at 23 usable cases.

Topical indexing

These 23 cases were then indexed for all topical content. The PI closely watched and listened to the recordings, taking note of the following information: 1) the topic of the talk; 2) the timing of the topic in the consultation (using the time code on the recording); 3) which participant initiated the topic (when discernible). In addition, the PI made some initial comments and observations.

The primary purpose of the topical indexing was to identify sequences in which the participants were discussing either substance use or sexual activities. Culling the data for these topical domains required some decisions about category parameters. The domain of substance use included the following specific substances: tobacco (cigarettes), alcohol, and illicit drugs (marijuana, cocaine, heroin). Any sequences in which these substances were discussed were included. Deciding what to include under the domain of sexual activities involved a bit more judgment. Relatively straightforward instances included those related to sexual partnerships (quantity, duration, etc.), sexual functioning (e.g. erectile dysfunction), birth control, and sexually transmitted infections. An example of a borderline case was a patient who complained of vaginal itching. While this is a sexual organ, the discussion did not really address sexual health or sexual behavior per se. However, when the physician recommended that the patient switch to cotton underwear, the patient, who was single and dating, joked that the physician must not want
her to “ever find a boyfriend.” The joke was apparently that simple cotton underwear is less attractive than the underwear the patient was used to wearing. This was, in a sense, relating her health concern to her pursuit of sexual partnerships, though the discussion essentially ended there. Though this case was counted as an instance of a sexual health discussion, it was not used in the analysis. In general, a wide net was initially cast, with the expectation that the corpus would be refined as the analysis progressed.

Even though substance use histories and sexual histories are considered routine components of a comprehensive medical history, physicians and patients in these data were somewhat inconsistent in addressing them. There were four cases in which there was no discussion of substance use or sexual matters at all. These four cases were not used in this analysis. Among the remaining 20 cases, there were eight that included substance use discussion(s), but no discussion of sexual matters. There were also three cases that included discussion(s) of sexual matters, but no discussion of substance use. This outcome is consistent with the literature in these areas, which suggests that physicians and patients are generally disinclined to consistently address these matters. It is possible that physicians and patients were especially reluctant to address these matters while being video recorded.

In the remaining nine cases, physicians and patients addressed both topical domains. In some cases, there were multiple, separate discussions of one or both topics within the same consultation. For example, during the sexual history portion of one consultation, a patient reported that his wife had had an affair. Much later in that consultation, the physician initiated discussion of STI testing as it related to the patient’s
wife’s infidelity. Though these matters were clearly related, they were separate sequences of interaction.

All told, there were 17 sequences (discussions) regarding sexual matters and 19 sequences regarding substance use. These 36 sequences comprise the corpus for this analysis.

**Transcription**

These 36 cases were transcribed by the PI using a specialized notation system developed by Jefferson (1974). The typographic symbols of this system are meant to capture not just spoken words, but all manner of speech sounds (e.g. “uh” or “mm”), phonological contours (i.e. pitch, speed, emphasis, etc.), pauses, overlapping speech, and many other features of naturally occurring speech. All transcripts in the analysis are presented in this notation system.

**Data Analysis**

The analysis operates from an ethnomethodological framework and employs the empirical tools of conversation analysis (CA). In this subsection, I provide an overview of the central assumptions and research practices associated with ethnomethodology and CA.

**Ethnomethodology**

Harold Garfinkel developed the core principles of ethnomethodology in the mid-1950s, though his work did not reach a wider audience until the publication of *Studies in Ethnomethodology* in 1967. According to Heritage (1984), Garfinkel initially coined the term ethnomethodology “as a label to capture a range of phenomena associated with the use of mundane knowledge and reasoning procedures by ordinary members of society”
Garfinkel developed this perspective in large part as a response to what he perceived as limitations in Parsonian structural functionalism (1937), particularly its orientation to the rationality of social action and its framing of social actors as analytically subordinate to the structural-functional forces that act upon them. Parsons takes the position that social actors internalize cultural norms and that these norms serve as causal dispositions to action. Norms are thus conceptualized in terms of their regulative force. When social actions appear inconsistent with cultural norms (i.e. murder), Parsons argues that this should be understood as a byproduct of the actor’s incomplete or erroneous internalization of these norms. For Parsons, who rejects intersubjectivity as a secondary artifact of multiple social actors’ mutual apprehension of immutable social facts, it is objective scientific logic, not common-sense reasoning, that should serve as the proper measure of the rationality of social action.

Borrowing insights from the phenomenology of Husserl and Shutz, Garfinkel developed a perspective that emphasized the active sense-making work of social actors engaged in practical activities. This perspective departs from Parsons on many key issues. Whereas Parsons treats norms as regulative of social action, Garfinkel treats norms as constitutive of social action. For Garfinkel, norms do not serve as cognitive antecedents of action, but rather provide methods for recognizing that a social action or social situation has (or has not) been achieved. Norms provide members with the functional requirements for producing sensible, meaningful conduct. Whereas Parsons treats deviant behavior essentially as a product of faulty socialization, Garfinkel emphasizes the persistent interpretive work of social actors to render ostensibly deviant behavior sensible by reference to alternative frameworks of action (i.e. the actor is joking, drunk, deranged,
etc.). Whereas Parsons rejects intersubjectivity and commonsense reasoning as illusory and/or defective in comparison to scientific logic, Garfinkel treats these phenomena as indispensable resources for the creation and maintenance of a manageable social world.

The contrast between Parsons and Garfinkel on the issue of intersubjectivity and commonsense reasoning may be best understood in terms of the contrast between idealized social action and practical social action. Garfinkel argues that, if social action were to proceed from an idealized scientific perspective, the task of completely describing or apprehending any object or social action would require access to a potentially infinite range of specifiable details. As an illustration, Garfinkel proposes that someone who is following a recipe could rightly wonder exactly how much salt is in a “pinch” or what counts as “gentle folding.” While such details may be specifiable to an extraordinary degree, Garfinkel argues that more detail can always theoretically be requested and that no level of detail is ever truly “complete.” Of course, social actors engaged in everyday activities are not crippled by this kind of ontological imprecision. From an ethnomethodological perspective, social actors engaged in everyday activities are not concerned with scientific standards of rationality or precision, but rather are oriented to a “for-all-practical-purposes” standard for understanding. Faced with a theoretically infinite range of specifiable details, the details that actually turn out to be relevant for understanding any social object or action are determined emergently as a function of the practical work of the social actors engaged in the situation at hand. Garfinkel argues that social actors rely on one another to draw upon their intersubjective orientations and commonsense reasoning in determining what details are relevant for the formulation and interpretation of mutually recognizable social actions. Whereas Parsons
sees commonsense reasoning and intersubjectivity as defective approximations of objective scientific logic, Garfinkel demonstrates the critical role they play in the practical sense making upon which everyday social life is built.

**Conversation analysis**

Conversation analysis (CA) was developed by Harvey Sacks (1992) and his colleagues in the 1970s. Applying an ethnomethodological lens, Sacks sought to examine the systematic practices and knowledge that cultural members draw on to create and sustain the most basic form of social structure: human interaction. The basic goal of CA is to expose social actors’ methods for displaying and coordinating their communicative actions and sense making practices. According to Pomerantz and Fehr (1997), “conversation analysis gives particular attention to the details of the temporal organization of, and the various interactional contingencies that arise in, the unfolding development of action and interaction” (p. 66). A central assumption of CA is that talk and other forms of interactional conduct are produced in recognizably orderly ways so as to be sensible and intelligible to other interlocutors (Sacks, 1972). Talk provides for its analyzability, both for co-present interlocutors and for researchers. Conversation analysts work to expose and describe the methods interlocutors use to jointly produce meaning in emergent sequential environments.

The practical work of CA involves several stages. The first step is to produce tape recordings or video recordings of naturally occurring interaction. These data are then transcribed in a notation system developed by Jefferson (1974). Conversation analysts use transcripts in concert with recorded data in developing their analyses. The central goal of such analyses is to identify and describe naturally occurring interactional
phenomena. The range of phenomena that have been of interest to conversation analysts is far too varied to be fully represented here, but some of the more “classic” domains of inquiry have included: 1) conversational turn-taking behavior (Jefferson, 1986; Lerner, 2002; Sacks, Schegloff & Jefferson, 1974); 2) methods for displaying agreement/disagreement (Goodwin, 1983; Heritage, 2002; Jefferson, 1987; Pomerantz, 1984); 3) use of membership categories (Sacks, 1992; 1999; Psathas, 1999); 4) complaining and “troubles talk” (Dersley & Wootton, 2000; Drew, 1998; Mandelbaum, 1991/1992); 5) storytelling (Lerner, 1992); 6) repairing interactional problems (Schegloff, 1992); 7) delivering good and bad news (Maynard, 1992; 1998; 2003); 8) practices of information exchange (Pomerantz, 1980; 1988).

Once interactional phenomena of potential interest are located, they are compiled into collections of instances of those phenomena. These instances can then be closely analyzed to locate recurrent features or variations within the phenomenon of interest. In developing their understanding of interactional phenomena, conversation analysts examine the details of the formulation of those phenomena, where they occur sequentially, how they build on prior utterances, and how they project the relevance of subsequent utterances. On the basis of these details, conversation analysts show how utterances function in local sequential environments and show how the details of those utterances provide for their meaning or interpretation as social actions. For more on the practical work of conversation analysis, see Pomerantz and Fehr (1997), Hopper (1989), and Clayman and Gill (2004).

CA is well suited to addressing comparatively open-ended, exploratory research questions. According to Pomerantz and Fehr (1997), “[conversation analysis] rejects the
use of investigator-stipulated theoretical and conceptual definitions of research questions. Instead, conversation analysts attempt to explicate the relevancies of the parties to an interaction” (p. 66). Conversation analytic work tends not to be theory-driven, nor are claims generated through hypothesis testing. Claims are generated inductively by collecting and analyzing instances of interactional phenomena.

**Ethical Considerations**

Three ethical considerations significantly informed the process of data collection: (1) minimizing pressure on patients to participate; (2) ensuring the confidentiality of the participants; (3) minimizing the impact of participation on the quality of care that patients received. The steps taken to address these considerations are summarized below.

Patients may have felt pressure to participate in this study for several reasons. They may have believed that their physicians or the family practice administrators wanted them to participate. They may have felt somewhat intimidated by the institutional setting. They may have wondered if their participation or non-participation would affect the quality of care they would receive. Some patients may have felt they would receive better treatment if they participated³. To minimize pressure, the initial solicitation letter that patients received at the front desk indicated that the PI was not at all affiliated with the medical practice (the letter was also printed on University at Albany letterhead). The PI emphasized this with all patients who agreed to be formally solicited in the private office space. Patients were also assured that the study was not designed to systematically

³ Patients may have heard of medical studies that employ placebo treatments as part of an experimental design. They may have been concerned that they were being placed into a ‘treatment group’ or a ‘placebo group,’ either of which could influence the care they would receive.
alter the type or quality of care patients received, as might be the case in an experimental design. In addition, each patient was given a post-visit consent withdrawal letter that they could mail to the PI if they decided they did not want their data to be kept or used in the study. The rationale for the letter was to allow the patients to have additional time to reflect and also to make the final decision while outside the medical setting. The participation rate of 44% indicates that the majority of patients who were solicited felt they were able to decline.

For various reasons, not the least of which is the sensitive nature of the focal topics, ensuring the confidentiality of participants was of paramount importance. Patients might have reported embarrassing or illegal conduct. Physicians might have made medical errors that the recordings could verify. The most significant protection built into data collection was the certificate of confidentiality from the National Institute of Health. This allowed the PI to protect all study materials from subpoena. In addition, any identifying information that emerged in the discourse (e.g. names, hometowns, workplaces, etc.) was digitally ‘bleeped out’ of the audio track and pseudonymized in transcripts. Finally, numerical codes were generated for each office visit and these codes were used on all videotapes, digital files, and transcriptions associated with the project.

Although all participants were told that the study was not designed to alter the quality of care that patients received, the presence of the recording device may have nonetheless influenced what the participants were willing to discuss or how they discussed some topics. If, for example, a patient felt embarrassed to disclose medically relevant information about prior drug use or if a physician felt s/he shouldn’t put the patient ‘on the spot’ with the camera running, this would compromise the quality of care
the patient received at that visit. As part of the consent process, both physicians and patients were shown a list of topics that were typically included in a routine (comprehensive) history. While the PI did not disclose what the focal topics were, both sexual activity and substance use were on the list. The rationale was to alert participants to what might be discussed and to ensure that they felt comfortable with the possibility of addressing those matters on camera. It is difficult to gauge the extent to which the camera might have altered the participants’ conduct or the medical consequentiality of those alterations. The fact that some patients did disclose potentially embarrassing and/or illegal conduct suggests that the camera did not completely preclude attention to difficult topics, but this is sketchy evidence at best.
ANALYTIC CHAPTER ONE:
THE ENACTMENT OF STRONG CHARACTER

Identity and Identity Management: How Am I Using These Concepts in This Chapter?

In the literature review, I outline four aspects of identity that have been described by scholars of social interaction: discourse identity, situated identity, transportable identity (Zimmerman, 1998), and character (Goffman, 1967). A central assumption of scholarship in this area is that the relevance of any aspect of identity for conducting the social business at hand is provisional and emergent, shaped by a range of situational expectations and interactional contingencies. Depending on the circumstances, some aspects of identity may be more relevant for participants than others. In the ‘lifestyle’ history-taking data that I examined, the participants’ conduct appeared to be shaped primarily by concerns regarding two of the four types of identity: situated identity and character. This is not to say that discourse identity and transportable identity were never relevant to the interaction, just that concerns about situated identity and character better explain some of the ‘special’ interactional work that I observed in these histories.

Situated Identity and Character

To briefly review, a situated identity is essentially a social role, a person category whose relevance is tied to situational context (e.g. physician, patient, lawyer, mother, best friend). Shared cultural knowledge about these role identities provides resources for social actors to coordinate their participation in specific settings, activities, or situations. For example, someone may enact the situated identity of ‘lawyer’ in order to participate in a courtroom proceeding, but when that same actor encourages her child to eat her
vegetables at the dinner table, she enacts the situated identity of ‘mother.’ Both enactments rely upon shared cultural knowledge about these situations, the identities (or roles) that may be relevantly claimed within them, and the behavioral expectations associated with role incumbency. Situated identities are generally conceptualized as temporary, fragmentary, context-bound projections of self. Character, on the other hand, is conceptualized as a trans-situational aspect of identity, something taken to be “characteristic” of an actor (Goffman, 1967 p. 238) beneath the various situated identities s/he may claim. Character is a fundamentally moral concept; it refers to culturally idealized qualities of personhood, such as self-respect, self-discipline, integrity, and courage. To embody these qualities is to have ‘strong character.’ Although it is revealed (or not) in situated moments of interaction, character itself is understood to be a stable, defining aspect of self. In the data I examined, concerns regarding situated identity and character appeared to shape participants’ conduct in different ways.

With respect to situated identity, previous research has shown how social actors enact the roles of physician and patient through their interactional conduct (Ainsworth Vaughn, 1998; Boyd & Heritage, 2006; Frankel, 1994; Mishler, 1984; Stivers & Heritage, 2001). As with any situated identity, ‘physician’ and ‘patient’ are associated with specific sets of interactional expectations, obligations, and entitlements. For example, during history taking, the identities of physician and patient are enacted in part through the style and distribution of information-seeking activities. Physicians enact the physician role by asserting a measure of information-seeking initiative and by employing serialized clusters of systematic, closed-ended queries. Patients enact their reciprocal identity by responding to these queries in fitted, minimal fashion and by largely yielding
the information-seeking initiative to the physician. In doing so, both participants display their understandings of the institutional setting, the situated identities available to them, and the functional requirements for completing the history. Not surprisingly, I observed many of these same patterns in the routine lifestyle history-taking cases I examined. Physicians and patients behaved in ways that were constitutive of their situated identities. Their history-taking activities displayed a concern with fulfilling the institutional expectations for incumbents of these role identities.

In the two lifestyle domains I examined -- substance use and sexuality -- enacting the situated identities of ‘physician’ and ‘patient’ meant seeking and reporting information about matters that are regarded culturally as potentially sensitive or embarrassing. In these topical environments, the participants engaged in some rather special interactional work, including various forms of normalizing, accounting, evaluating, and interactional marking that have not been systematically observed in previous research on routine history taking. I argue that these activities cannot be fully accounted for in terms of the functional requirements of the physician and patient roles. Rather, this work appears to reflect a concern with projecting, preserving, or restoring the patient’s character, his or her image as a morally and normatively appropriate cultural member. That character might be at stake during routine lifestyle history taking is consistent with previous theory and research in this area. As noted in the literature review, substance use and sexual behavior have often been described as morally loaded spheres of activity, not all variations of which are viewed as equally appropriate or desirable (Klamen, Grossman & Kopacz, 1999; Mignon, 1996; Silverman, 1994). In
reporting on their activities in these domains, patients may feel that inferences about their character are at stake.

Character provides an analytically useful concept for making sense of these data, though I apply it in some ways that extend beyond Goffman’s (1967) initial conceptualization. Specifically, I employ the notion of ‘health consciousness’ as an aspect of character that appeared to be relevant for incumbents of the patient role. By health consciousness, I mean a concern with preventing and/or appropriately responding to health risks. While this was clearly not a part of Goffman’s initial description of character, it does embody certain aspects of the concept, such as self-respect and self-discipline, the ability to resist, “excessive involvement in…easy pleasures” (p. 220). Like other aspects of character, health consciousness is a moral concern; it implies a moral obligation to ‘take good care of oneself,’ or at least avoid self-destruction. Because lifestyle health is generally understood to be a product of more-or-less voluntary behavioral choices, there is often a sense of moral culpability enmeshed in these matters. Health consciousness is also consistent with Goffman’s notion of character in that it refers to something trans-situational about the actor, the attitude or approach s/he takes toward health management across a variety of situated contexts.

It is possible, perhaps even likely, that physician-patient consultations tend to occasion concerns about the apparent health consciousness of patients’ conduct. After all, physicians are understood to have a role-based obligation to evaluate how well a patient is taking care of him/herself and this may prompt patients to manage the impressions they create in this regard. But this does not mean that displays of health consciousness are necessarily required for, or constitutive of, the patient role. A patient may fulfill the
situational expectations of the patient role (e.g. by providing requested information in fitted, minimal formats) without necessarily displaying health consciousness. Likewise, a social actor may display health consciousness in non-medical contexts (e.g. when a vegan describes to a friend the health-based reasons for his/her dietary choice). For the purposes of this analysis then, I treat ‘patient’ as a situated identity one enacts in order to participate in medical encounters and ‘health consciousness’ as an aspect of character that may (or may not) emerge as relevant in those encounters.

It should be stressed that health consciousness was not the only aspect of character that appeared to be relevant during the lifestyle histories I examined. In some cases, the participants also appeared concerned with the more ‘traditional’ aspects of character that Goffman discussed, all of which are centered on issues of moral and normative desirability. In many cases, it was difficult to determine whether the participants were dealing with the health implications or the moral implications of lifestyle conduct or if, in fact, this distinction was even relevant for them. Research on the moral dimensions of describing health-related conduct (Bergmann, 1992; Heritage & Lindstrom, 1998; Silverman & Perakyla, 1990) suggests that the distinction may be murky at best. For example, if a patient defensively minimizes his/her reported alcohol use, does this reflect an orientation to the unhealthiness of excessive alcohol use or to its normative or moral implications? Or both? Ultimately, my goal is not to establish with perfect clarity that this or that feature of character is at stake in a given interaction. Rather, I am using the notion of character as broad analytic lens and working from the conversation analytic mandate to describe how various aspects of it were locally constructed and/or oriented to by the participants in particular sequences.
Identity Management

Having laid out the two aspects of identity that inform this analysis (situated identity and character), I now describe what I mean by ‘identity management.’ In general, identity management (or identity work) refers to those social actions that serve to enact, maintain, protect, or repair a claimed or expected aspect of identity. It can also be understood in the inverse as an effort to resist or deny an ascribable identity. The specific social actions that might count as identity work are tied contextually to the identity in question. Identity management can be explicit, such as when a speaker names an identity feature (e.g. “Speaking as a professor, I…”), though most interaction-based research has tended to emphasize the more subtle, implicit ways in which identities are claimed or made relevant (e.g. Zimmerman, 1998). In my view, this emphasis rightly reflects the everyday phenomenon of identity management. My reading of Goffman (1959) is that identity management is most appropriate and effective when it is inconspicuously woven into the threads of other ongoing social activities. Articulated from a social normative perspective, Goffman might argue that actors should not display an overt preoccupation with managing their identities, for such a preoccupation could undermine “expressive order” (1955, p. 215), the achievement of a smooth, self-assured stage production. Should identity management appear to be a preoccupation for the participants, it may imply that there has been some turbulence or misalignment in their performances.

Consistent with Goffman’s perspective, the kinds of identity management that I observed in these lifestyle histories was generally implicit, below the conversational surface. There were no explicit invocations of situated identities (e.g. “I’m going to ask some questions as your physician.”), nor were there unveiled assurances of strong
character (e.g. “I’m a really good person, so I don’t do drugs.”). A primary goal of this analysis then, is to describe the subtle and indirect interactional practices that participants used to accomplish identity work without making that the primary social business at hand.

In terms of identity management, what I was most struck by in these data was the resourcefulness with which patients appeared to be balancing (a) a concern with fulfilling the expectations of the situated role identity of ‘patient’ as it relates to the activity of routine history taking and (b) a concern with enacting strong character. While I would not argue that these identity concerns are necessarily incompatible, I would argue that enacting the situated identity of ‘patient’ presents certain interactional and institutional constraints on the enactment of strong character. As previous research has shown, routine history taking represents a relatively restrictive interactional environment for patients (Stivers & Heritage, 2001; Heritage & Boyd, 2006). Physicians employ standardized, closed-ended queries that prompt patients to report medical information in minimal formats, leaving little interactional space or institutional warrant for patients to reveal, protect, or repair their character. But as this analysis shows, interactants can adapt and exploit the interactional resources available to them to accomplish identity work tacitly within those constraints. Thus, I do not particularly emphasize the work of enacting the situated identities of ‘physician’ and ‘patient.’ Other researchers have addressed this and continue to do so. Rather, I focus on the ways in which the participants, primarily patients, worked to tacitly enact strong character while still visibly fulfiling their situated identity-based obligations to efficiently and accountably progress through the history.
I offer two disclaimers about how I am approaching the notion of identity management empirically. First, Goffman frames identity management as an intentional, motivated, and goal-oriented interactional project. In my view, it is both sensible and useful to think of identity management as having these kinds of cognitive bases. Insofar as we can understand an actor’s goals, we can better appreciate how that actor designed his/her talk to realize them. However, it has been difficult to reconcile this motivated, goal-oriented framing of identity management with the traditional methodological and argumentative conventions of conversation analysis. One issue is that my data are in the form of video-recordings of naturally occurring interaction, so I have no real credible access to cognitive states such as motivations, goals, or intentions. Complementary interview or survey data could have bolstered claims in these areas. Another issue is that one of the traditional commitments of conversation analysis is to avoid attributing motives, intentions, or goals to interlocutors’ talk (Clayman & Gill, 2004). Instead, conversation analysts describe how talk itself is designed and organized and how it functions in particular sequential contexts, without appealing to what speakers might have intended with their talk.

I have worked to address these tensions in two ways. First, I proceed with the qualification that participants appeared to be engaging in identity management. This is an inference I am making based on close and repeated examination of these data. I freely admit that I cannot know for sure what the participants intended with their talk, but identity management provides a compelling account for some interactional conduct that might otherwise be difficult to understand. Ultimately the point of this analysis is not to establish what participants’ intentions were, but rather to use identity management as an
analytic lens to help explain some of the interactional complexities of lifestyle history taking. A second way I work to address these tensions is by departing in some ways from conversation analytic orthodoxy. While I retain CA’s emphasis on describing the design and functional potential of talk, I situate those claims within a theoretically-informed assumption that the interactional conduct I observed was influenced, in part, by concerns about identity. Social actors’ concerns, intentions, goals, etc. are often disattened by conversation analysts, but if they are experientially real for the participants, it is worthwhile to see how they can help us make sense of the interactional conduct we see.

In terms of argumentative style, bringing a priori concepts like ‘identity’ or ‘character’ to bear on my data could be seen as less inductive than some traditional strands of conversation analysis. At the same time, the relevance and usefulness of these concepts did emerge inductively for me as a result of the “unmotivated observation” (Hopper, 1989) that is often encouraged in the early phases of data analysis. Again, my goal is not to impose exogenous concepts on the data, but to use these concepts to help account for what I see in the data.

Although I have framed this approach as something of a departure, it is not unprecedented. For example, Mandelbaum and Pomerantz (1991) argue that conversation analysts can (and do) make inferences about participants’ concerns, goals, or projects, and that these inferences often enrich our understanding of the social actions being implemented. They argue that various types of concerns can shape interaction, some of which precede interaction (such as planning an approach to a ‘difficult’ phone call) and some of which emerge spontaneously from the contingencies of interaction. They caution that inferences about actors’ concerns should be grounded in the observable details of the
data and that claims should be properly calibrated to the evidence. In some cases, claims may be made with confidence; in others, only tentative possibilities may be offered.

The second disclaimer is that I do not see identity management as the only interactional or instrumental concern to which the participants may have been orienting. Indeed, a key assumption of conversation analysis is that talk-in-interaction can be multi-functional. Returning to the example of a patient’s defensive minimization of alcohol use, s/he may be motivated in part by concerns about character, but also by a concern to close down the topic and move the consultation along to matters that s/he sees as more pressing. While I maintain an analytic focus on the identity management potential of the talk, I do not argue that this was the only concern that was operating for the participants or that it is the only analytic lens that can help us to understand their conduct.

What Did the Enactment of Strong Character Look Like Empirically?

In this chapter, I examine cases in which patients’ responses to physicians’ lifestyle queries portrayed their conduct as medically and/or morally appropriate. Patients did this by enacting tacitly evaluative, ‘no-problem’ stances toward the information they were reporting. These responses ostensibly fulfilled the situational expectations of the patient role, but in the details of their formulations, patients also made the case that their conduct should be understood as medically and/or morally normal, unproblematic, or even desirable. When patients formulated their responses in these ways, I argue that they were working to enact strong character while operating within the constraints of the patient role. Thus, empirically speaking, the enactment of strong character generally involved subtle, implicit interactional practices that invoked and relied upon shared cultural knowledge about health and lifestyle. Consistent with Goffman’s view of identity
management, the enactment of strong character never appeared to be the primary, on-record business of the interaction. Rather, the participants communicated in ways that maintained a focus on the practical activity framework of routine history taking and their institutional roles within it.

It should be noted that patients did not always respond to lifestyle queries in ways that claimed a ‘no problem’ state of affairs; that is a feature of the cases examined in this chapter. In the next analytic chapter, I consider cases in which patients appeared to do just the opposite. That is, they responded in ways that proposed or acknowledged that their conduct had been potentially problematic.

Organization of the Analysis

This chapter is organized in two main sections. In the first section, I describe and illustrate three interactional practices that patients used to enact strong character. I regard these as the primary findings of this chapter. In the second section, I describe and illustrate physicians’ responses to patients’ enactment of strong character. The rationale for examining physicians’ conduct comes from Goffman’s dramaturgical perspective. He conceptualizes identity management as a coordinated process among all actors in the ‘scene.’ Each actor’s conduct might support, enhance, threaten, or even disattend the claimed identities of other actors. While I ultimately argue that physicians appeared to be fairly uninvolved in patients’ enactment of strong character, I do present some tentative arguments and evidence about how their conduct was supportive of patient character.

Section 1: Patients’ Practices for Enacting Strong Character

In this section, I describe and illustrate a range of interactional practices used by patients that served to enact strong character. These practices are: (1) Employing a
syntactically, intonationally, or interactionally marked ‘no-type’ response; (2) volunteering normalizing details about the type, quantity, frequency, or circumstances of conduct; (3) Evaluating conduct as normal or unproblematic. It should be noted that all of the data for this chapter come from only one of the two focal topical domains in this study, that is, substance use. This was not a methodological or analytic decision on my part; it was a feature of the data. In the sexual histories I collected and analyzed, I found no cases in which a patient appeared to be enacting strong character in their initial descriptions of their sexual conduct. I return to this issue in the conclusions chapter and offer some speculative possibilities for why this was the case.

1. Employing a Syntactically, Intonationally, or Interactionally Marked ‘No-type’ Response

In order to appreciate the kinds of ‘special’ marking that patients sometimes employed in their reporting activities, it will be useful to briefly discuss and illustrate the role of simple, unmarked responses during history taking. As I have noted, the interactional structure of routine history taking is generally organized around closed-ended queries from the physician and fitted, minimal responses from the patient. Many of the physician’s closed-ended queries are designed to establish the presence or absence of specific symptoms, conditions, or behaviors. This is particularly prevalent in physicians’ initial queries within a topical domain, where the subsequent interactional trajectory often depends on whether the symptom or condition is present or absent⁴. When patients report the absence of a symptom, condition, or behavior, they typically do so by providing a

⁴ In general, if the symptom, condition, or behavior is present, the physician will seek additional relevant information. If it is absent, the physician will move on to a different query or topical domain.
simple, straightforward (i.e. unmarked) “no.” In terms of information provision, patients and physicians treat this as sufficient and appropriate. The following case illustrates this pattern:

A0803|8.30|"Not A Lot"
2. Pat:⇒ No.
3. (1.7) ((Physician typing in Patient’s EMR))
   The patient’s “No.” in line 2 was minimal and intonationally unmarked. The terminal intonation conveyed that the response was complete. In making an entry in the patient’s electronic medical record (EMR), the physician displayed receipt, thereby treating “No.” as a sufficient and appropriately informative response to the query. This pattern also held in some aspects of lifestyle, as illustrated by the following cases dealing with cigarette use:

F0928|4.09|"Not Writing"
1. Doc: U:m d’you smoke, ((looking at EMR))
2. Pat:⇒ No.

R1025|7.22|"College Drinking"
1. Doc: D’you smoke cigarettes?
2. Pat:⇒ Nope.

A0803|8.30|"Not A Lot"
1. Doc: D’you have any: u:m .h any history of smoking?
2. (.)
3. Pat:⇒ No.
These patients treated a simple, unmarked “no” as sufficient for reporting the absence of cigarette use. These relatively routine cases serve as a backdrop against which to appreciate the special marking that patients used when reporting the absence of more normatively problematic lifestyle conduct. Like in the above cases, these marked responses served to inform the physician that the behavior in question was absent. However, the marking also appeared to serve an identity management function. Through their marked ‘no-type’ responses, patients enacted the stance that the conduct in question was not just absent, but ‘out of the question’ for them, totally inappposite to their identity or life circumstances.

There were three types of resources that patients used to mark their ‘no-type’ responses: syntactic, intonational, and interactional. By syntactic marking, I am referring to lexical choices, words or phrases that are more elaborate than a simple ‘no.’ By intonational marking, I am referring to the sound quality of the response, its pitch, volume, emphasis, and other phonological contours. By interactional marking, I am
essentially referring to patients’ producing their responses in overlap with physicians’ queries, an issue of sequential positioning.

Most of the instances of this practice involved patients’ reporting not using drugs, meaning illicit or recreational ‘street’ drugs. Use of such drugs is illegal, normatively problematic and, in some cases, medically problematic. In comparison with cigarette use or alcohol use, drug use is regarded culturally as more deviant. When patients employed marked denials of drug use, their conduct was rendered sensible by reference to these shared cultural understandings about the relative deviance of drug use. In framing drug use as ‘out of the question,’ patients tacitly enacted strong character, both in terms of health consciousness and moral virtue.

One instance of this practice did not involve drug use. In that case, a pregnant patient provided a marked denial of alcohol use. Because alcohol use can lead to various birth defects, including fetal alcohol syndrome, there is a greater sense of deviance associated with drinking while pregnant (Baxter, Hirokawa, Lowe, Nathan & Pearce, 2004). As Baxter et al. report, the moral implications of responsible motherhood were frequently implicated in informants’ perspectives on drinking while pregnant. That case is presented last in this section.

Case 1: A0803|8.30|"Not A Lot"

1. Doc: S:ocial history.=D’you ha:ve any: u:m .h any
2. history of smoking?
3. (.)
4. Pat: No.
5. ((6 lines omitted))
6. Doc: Drugs,=>marijuana cocaine [hero-< ]
In line 6, the physician queried the patient about drug use. She listed a few common street drugs, perhaps to help clarify the query. In line 7, the patient responded in the negative, but not with the same type of routine, unmarked “No.” that she had used to indicate that she does not smoke cigarettes (line 4). She shifted to “°Na::h°,” which in this context had a somewhat flippant or dismissive quality, especially given its marked intonational contours. The patient elongated the vowel sound significantly and reduced her volume and timbre to a husky whisper. With this marked prosody, “°Na::h°” implied that drug use was not just absent, but irrelevant for her. She also responded in overlap with the physician’s recognizably incomplete list of street drugs, effectively cutting off her full query format. Through these features, the patient treated the physician’s querying her about drug use as unnecessary, a technical formality to be quickly dispensed with. She cast drug use as a ‘non-topic’ for her, utterly inapposite to her life circumstances.

In line 8, the physician displayed receipt of the patient’s “°Na::h°” by typing in the EMR. The physician showed that she had sufficiently heard the patient’s response despite the overlap. Nonetheless, the patient reproduced the same response in the clear in line 9 with virtually identical intonational features. This was redundant on informational grounds. However, it further bolstered the sense of strenuous denial. By framing her not

This physician recurrently employed this listing format; it was a standardized practice for her.

This patient generally spoke quietly. However, her overall prosody was qualitatively different when she produced “°Na::h°.”
using drugs in terms of a principled stance rather than a simple absence of conduct, the patient appeared to enact strong character.

**Case 2: R1025|7.22|"College Drinking"

1. **Doc:** D’you smoke *cigarettes*?
2. **Pat:** Nope.
3. ((29 lines omitted))
4. **Doc:** Any history of uh drug use.
5. **Pat:** Naw:: >°I don’t use any drugs°<

In line 4, the physician queried the patient about drug use. Like in the previous case, the patient responded with an intonationally marked variant of the more standardized “no” (“Naw::” in line 5). This contrasts with his somewhat nonstandard but essentially unmarked “Nope.” in response to an earlier cigarette use query (lines 1-2).

The patient’s elongation of “Naw::” gave this response a more emphatic quality. The patient continued on with “>°I don’t use any drugs°<.” This expansion did not add any information to the response, but served to frame the patient’s not using drugs as a policy or an ongoing commitment, not just happenstance. The patient’s use of “any” can also be heard as denying use of a whole range of substances that could count as ‘drugs.’ Thus, this expansion further constituted drug use as inapposite to the patient’s lifestyle. Like in Case 1, the patient’s framing his not using drugs as a principled stance appeared to be character-implicative.

In the next two cases, the patients employed many of these same features, but also employed a phenomenon known as “oh-prefacing.” Heritage (1984; 1998; 2002) describes “oh” as a “change-of-state marker,” a way for speakers to display various kinds of cognitive shifts (e.g. surprise or realization). These cognitive shifts can also register
different stances toward the actions or utterances to which they are responsive. For example, in prefacing a response with “oh,” a speaker can mark that prior action or utterance as unexpected, ill fitted, or inapposite (Heritage, 1998). This is essentially how the patients appeared to be using “oh-prefacing” in these two cases, treating the physician’s query and/or its subject matter as inapposite to the patient’s life circumstances. I stress that I do not see these patients as taking exception with the physician’s history taking activities. Rather, I argue that patients exploited certain features of “oh-prefacing” in order to project strong character.

Case 3: A0718(1)7.51|"Drugs in Your Whole Life"

1. Doc:  =Are you a dr_inker?
2. (0.7)
3. Pat:  Oh no I gave that up, (0.5)
4. Doc:  An’ [did you] ever do drugs in yer whole lif_e,=
5. Pat:  [W- w-]

In line 4, the physician queried the patient about drug use (“An’ did you ever do drugs in yer whole lif_e,=”). The patient was 87 years old at the time of the consultation, which may account for the physician’s use of heavily past-oriented temporal markers like “did,” “ever,” and “in yer whole lif_e.” The patient employed “oh-prefacing” in reporting that she has not used drugs (“=O:h not dru gs.” in line 6), treating even the prospect of her using drugs as out of the question. Other features of the formulation also enhanced this hearing of her utterance. The patient stressed and elongated portions of her utterance, performing it as a strenuous denial of drug use. The patient also formulated her report as a negation of the term ‘drugs’ (“not dru gs”). The coherence of this formulation relied in
part on her prior report of having used alcohol in the past\(^7\) (line 3). In this sequential position, the marked negation of drugs (the next category of substances to be inquired about) maximized the claimed contrast between these activities. The meaningfulness of the contrast relied upon shared cultural understandings about the differences between alcohol and drugs as categories of substances. Whereas some alcohol use is normatively appropriate, drug use is both illegal and more normatively deviant. In her “righteous rejection” (Boyd & Heritage, 2006) of drug use, the patient appeared to be working to display her strong character.

**Case 4: A0718(2)3.10”Not a Heavy Drinker”**

1. Doc: A[: n]d, (. ) how ’bout any drugs.=>Marijuana=
2. Pat: [Yea:h.]
3. Doc: =co[caine=her]oin,<
4. Pat: → [Oh no.]
6. Pat: [No,]

In lines 1 and 3, the physician queried the patient about drug use. The patient employed “oh-prefacing” to indicate that she does not use drugs (line 4). By responding in overlap, the patient added an emphatic quality to her reporting not using drugs, treating the physician’s listing of candidate drugs as unnecessary for her circumstances. She rejected in sweeping fashion all possible members of the category, ‘drugs.’ In overlap

\(^7\) The patient also used “oh-prefacing” in her response to the physician’s alcohol use query (“Oh no I gave that up,” in line 3). It is possible that the patient was trading on the cultural assumption that the elderly do not use alcohol, hence the warrant for treating the query as unexpected. The prosody is less marked in this case, so I focus my analytic attention on the clearer instance of “oh-prefacing.”
with the start of the physician’s next query, the patient again said “No,” (line 6). She may have done this to respond in the clear or to emphasize that there was absolutely nothing at all to report about drugs. Like in Cases 1-3, the patient appeared to be enacting a character-implicative anti-drug stance, not just an absence of that behavior.

The next case involves the aforementioned pregnant patient providing an intonationally marked report of not using alcohol. The physician was well aware that the patient was pregnant from previous interactional context.

Case 5: F0405|1.49|"Pregnant Alcohol"

1. Doc: A:right d’you ↑smoke
2. Pat: No.
3. (0.7)
5. Doc: Coffee=caffeine,
6. (.)
7. Pat: pt U:m no:. ((Patient shakes head “no”))
8. Doc: Prob’ly not much right [no:w right,]
9. Pat: [ No: not ] at a(h)ll-
10. .hh eh heh heh
11. Doc: A:right.=Alcoho:1,
12. Pat:→.h ↓N(ay)o:. ((Patient shakes head “no”))

In response to the physician’s cigarette use query in line 1, the patient provided a routine, unmarked “no.” In line 5, the physician queried the patient about caffeine use, another substance that some physicians ask about during a substance use history. The patient reported that she does not use caffeine, again in a fairly unmarked fashion (“U:m
no:.”). Although the patient had already answered, in line 8 the physician displayed his expectation that the patient was likely limiting her caffeine use (“Prob’ly not much right no:w right,”). By emphasizing “right no:w,” the physician tacitly surfaced the patient’s pregnancy as a warrant for limiting caffeine use. He also included the tag, “right,” which further displayed his expectation that the patient was limiting her caffeine use for this reason. This utterance appeared to have a knowing and slightly playful quality. In lines 9-10, the patient confirmed the physician’s expectation, even upgrading from “not much” to “not at a(h)ll-.” The patient laughed during and after this utterance, displaying recognition of the slightly playful quality of the physician’s prior turn. Nonetheless, she cast herself as knowledgeable and fully committed to the health of her pregnancy insofar as “everyday” substances are concerned. Up to this point, the patient had reported not using cigarettes or caffeine and, in collaboration with the physician, established that her pregnancy was at least part of the reason.

In line 11, the physician receipted this report (“A:right.”) and immediately latched an alcohol use query (“=Alcohol,”). At this point, the physician had every reason to assume that the patient was not using alcohol, but queried her anyway. This is a potentially risky move in terms of patient rapport, but most medical training literature would suggest that physicians should try to be this thorough (Clark, 1995). By providing an elliptical query format (dropping everything but the word “alcohol”) the physician may have been working to frame the query as a standardized checklist item, something to ask as a formality. This framing could possibly soften the appearance that the physician was being insensitive to the patient’s emerging depiction of her pregnant lifestyle.
In line 12, the patient provided an intonationally marked “\(\downarrow N(ay)o:\)” It is difficult to adequately capture the intonational contours of her response using conversation analytic transcription symbols. Her tone was emphatic and serious. It was particularly striking in its contrast from the higher pitched, laughter-tinged quality of her previous utterance. The patient appeared to shift gears intonationally to deal with the question of her using alcohol while pregnant. Through this marked “no,” the patient appeared to enact a principled and health-conscious stance toward her not drinking while pregnant.

In my view, the use of marked ‘no-type’ responses represents an elegant solution to the tension between the enactment of the situated patient identity and the enactment of strong character. Patients fulfill their situational obligations by employing minimal formulations (e.g. “Oh no” or “Na:h”) that answer the query and allow efficient progress through the history. But by marking these minimal formulations, patients can also tacitly make claims about their character, their capacity to behave in culturally approbated ways.

2. Volunteering Normalizing Details About the Type, Quantity, Frequency, or Circumstances of Conduct

When a patient responds to a routine query by indicating the presence of a symptom, condition, or health behavior, the patient often does more than simply saying “yes.” When it is contextually relevant to do so, patients may provide additional details, drawing on their own knowledge and health experiences to anticipate what the physician might be after (Stivers & Heritage, 2001). This is consistent with Pomerantz’s (1988) claim that when recipients respond to information seeking actions, they don’t just answer the question literally. Rather, they make inferences about the information seeker’s
purpose in seeking information and shape their responses around those inferred purposes.

The following case illustrates this pattern:

A0813|2.00|"C-Section"

1. Doc: Have y’ever had su:rgery?
2. (0.5)
3. Pat:→(hh) I:- u:m two cee section,
4. Doc: Okay, ((Physician typing in Patient’s EMR))

In this case, the patient’s response in line 3 (“(hh) I:- u:m two cee section,”) displayed the inference that the physician’s purpose in seeking information about prior surgeries was to find out which specific surgeries she had undergone. The physician receipted the patient’s report affirmatively (“Okay,” in line 4) and made an entry in the EMR, both of which cast the patient’s volunteering additional information as utterly appropriate. It is thus not unusual or untoward for patients to volunteer unrequested information during routine history taking; doing so can even help to streamline the history.

In this section, I describe the kinds of detailing that patients volunteered when reporting on their lifestyle conduct, specifically their alcohol use. While the activity of detailing can occur for different reasons during a comprehensive history (Stivers & Heritage, 2001), the specific kinds of detailing that patients volunteered in this topical domain accomplished more than supplying relevant information. Their detailing tacitly made the case that their alcohol use is normal or unproblematic. They described their alcohol use in ways that invited the inference that they are moderate, self-disciplined, and health conscious persons, that is, persons of strong character. This work traded on shared
cultural knowledge about the type, quantity, frequency, and circumstances of alcohol use. This kind of work is similar to what Drew (1998) has described as defensive detailing.

For the first instance, I return to Case 4, which I had previously analyzed for the patient’s marked rejection of drug use. Here, I examine the alcohol-related exchange that occurred just before that sequence. This case is quite rich, but as I argue, some of the richness may have been related to the query format that the physician employed.

Case 4: A0718(2)|3.10|"Not a Heavy Drinker"

1. Doc: Are you a s:moker ma’am?
2. Pat: Yes I am.
3. ((9 lines omitted))
4. Doc: Are you a drinker?
5. (0.2)
6. Pat: → pt I drink bee:rs every now an’ ↓ then. I’m not a
7. → (0.2) heavy drinker not like that=maybe once (’n)
8. → a whi:le on the wee kend I’ll have a couple er
9. → sup’m like that ‘n that’s a:ll;

In line 4, the physician queried the patient about her alcohol use (“Are you a drinker?”). This query format was not common in these data. Whereas most physicians queried patients using an activity-based format such as, “Do you drink?,” this physician used a person category-based format, framing alcohol use in terms of membership in the category of “drinker.” Because this category term has cultural associations with excessive or problematic drinking, it is potentially counterproductive to employ it during routine substance use history taking. Rather than simply eliciting information, it may prompt defensive responses as the patient works to resist the applicability of this culturally
loaded term. It should be noted that this physician employed category-based substance use query formats with other patients as well, suggesting that this format was something of a routine practice for this physician. That is, it does not appear that this format was selected based on this particular patient and her apparent circumstances. It should also be noted that the physician had used the category term, “smoker” just moments earlier to query the patient about cigarette smoking ("Are you a s:moker ma’am?" in line 1). The patient reported that she was a smoker, maintaining the category-based framing by claiming incumbency in it ("Yes I am."). This provided for the physician’s use of the category term “drinker” to be heard as a recurrent or routine format for her, which might soften the identity implications.

The patient’s response in lines 6-9 is fairly elaborate and could be seen as somewhat defensive. As noted, this defensiveness may be related to the physician’s query format. However, as subsequent cases will show, other patients also used these same kinds of resources in response to more standard activity-based queries. Although this patient may have been unusually elaborate in her detailing, the knowledge and resources she invoked were typical of patients reporting on their alcohol use.

In her response, the patient volunteered details about the type, quantity, frequency and circumstances of her alcohol use. She specified that she drinks “bee:rs” (line 3), which may be regarded culturally as more innocuous than other types of alcohol.8 In line

8 It is widely known that there is roughly the same alcohol content in one beer, one glass of wine, one mixed drink, and one shot of straight liquor. Nonetheless, members of a culture may share certain understandings about the sort of drinking (or drinker) associated with each type of alcoholic drink. My sense is that beer is understood in this culture as the most innocuous type of alcoholic drink. Straight liquor is regarded as the most potent type of alcoholic drink. Thus, I am not surprised to report that I have no instances in which a patient reports, “I drink shots of tequila every now and then.”
5, she reported a quantity of “a couple.” The phrase “a couple” can be used to mean precisely two items, but is also used more generically as an idiomatic gloss for a small quantity. In using this phrase, the patient was engaged not just in reporting information, but suggesting what should be made of that information. The patient provided two versions of the frequency of her alcohol use: “every now and then.” (line 3) and “once (‘n) a while” (line 4-5), both idiomatic phrases that claim infrequent (i.e. unproblematic) use. The patient also volunteered that she uses alcohol on the weekend, a time period during which it is more culturally permissible to drink alcohol. Weekend drinking may also implicate ‘social drinking’ which is also more culturally permissible than drinking alone (i.e. non-socially), which is widely understood as a risk factor for problem drinking (Clark, 1995). In adding “‘n that’s a:ll;” to her quantity formulation (“I’ll have a couple er sup’m like that ‘n that’s a:ll;”) the patient implied that she was oriented to an ‘upper limit’ of her drinking. In claiming to operate with an upper limit, the patient further cast herself as moderate and responsible in her drinking behavior. By volunteering this rather elaborate description of her alcohol use, the patient abundantly fulfilled the informational requirements of the patient role while also tacitly enacting strong character. Similar arguments may be made about Cases 6 and 7 below:

Case 6: F0928/4.09|“Not Writing”

1. Doc: .hh U:m d’you drink,
2. (.)
3. Pat:→ Social, (1.0) couple beers maybe::: a w- y’know a
4. → week.

In line 3, the patient began his response with the term, “Social,” ostensibly a shortened form of ‘social drinking.’ The patient relied upon the physician to understand
social drinking as implying drinking in a group setting or at gatherings where it would be appropriate to use alcohol (clubs, bars, parties, etc.). The very notion of social drinking implies a kind of localized normative consensus; it is a context for drinking in which “everyone else is doing it.” In beginning his response with “Social,” the patient provided for his subsequent report on the quantity/frequency of use to be understood as occurring within a normatively appropriate circumstance.

Like in the previous case (Case 4), the patient employed the quantity term “couple,” which can be heard as precisely two items or as a gloss for a small amount. Under either interpretation, this is a quantity that is recognizably unproblematic, particularly when considered within a frequency of one week. Based on these amounts, the patient would rarely, if ever, become intoxicated. The patient also specified that he drinks beer, a culturally innocuous form of alcohol.

Case 7: A0718(3)|9.39|"Quick Sub History"

1. Doc:  U:m:, (0.2) ptuh (.) alcohol.
2. (0.7)
3. Pat:  ptuh ↑U::m ↑couple glasses uh wine a week.
4. Doc:  ""Okay."" ((Physician writing in chart))
5. Doc:  ""Occasional.""

Case 3 is similar to Case 2 in terms of the measures of quantity/frequency that the patient employed. She reported drinking “↑couple glasses of wine a week,” which is a recognizably modest pattern of alcohol consumption. In this case, the patient volunteered that she drinks wine. Like beer, wine may be culturally regarded as more innocuous than other forms of alcohol. In fact, moderate wine consumption could be considered health
conscious by virtue of the antioxidants, a fact that a physician explicitly invoked in a different case in these data. Wine is also commonly paired with meals and it is possible that the patient was inviting that inference with her relatively modest estimation of weekly consumption. In making the case that her wine consumption should be understood as modest, the patient appeared to be enacting strong character.

As with patients’ use of marked ‘no-type’ responses, their use of voluntary detailing can be understood as a way to balance a concern with fulfilling the patient role and a concern with enacting strong character. Their detailing supplied considerably more information than was explicitly solicited, which displayed awareness of, and sensitivity to, the activity context of history taking and their primary role within it as reporters of information. At the same time, this detailing provided the interactional space and discretion to lace their descriptions with features that tacitly claimed strong character.

3. Evaluating Conduct as Normal or Unproblematic

Given their specialized training and expertise, physicians are entitled/obligated to evaluate the medical implications of what patients report. Physicians are understood to have legitimate authority to make sense of patients’ health circumstances as normal/abnormal, healthy/unhealthy, etc. On the basis of their evaluations, physicians engaged in history taking make decisions about whether it is appropriate to move on to another topical domain, seek additional information, or provide some kind of medical intervention (such as proposing tests, treatments, or modification of health behaviors). During routine history taking, patients generally conform to this model, providing
information while allowing the physician to evaluate the medical implications of that information\(^9\).

However, during lifestyle history taking, patients did not just provide information about their conduct; they also provided evaluations of their conduct. I do not mean to suggest that patients offered formal or explicit medical evaluations, as physicians might be expected to do. But as I show, patients did treat themselves as capable of assessing their own conduct with respect to some normative standards. In some cases, they provided only an evaluation without any specific information, essentially precluding the physician from making his/her own sense of the patient’s conduct. This could be seen as the strongest version of this practice. While these cases do not contain the kinds of elaborate marking or detailing visible in previous cases, it is a rather special interactional move for patients to provide evaluations rather than information during routine history taking. I discuss some implications of this in the conclusions chapter.

For the first instance, I return to Case 1, which I had previously analyzed in terms of the patient’s marking her report of not using drugs. Here, I discuss her providing only an evaluation of her alcohol use.

**Case 1: A0803|8.30|"Not A Lot"**

1. **Doc:** Social history. =D’you have any: u:m .h any

\(^9\) Recent research on patients’ lay diagnostic reasoning suggests that patients do evaluate the medical implications of their symptoms and health behaviors and even find ways to convey their perspectives to physicians during problem presentation (Gill, Pomerantz & Denvir, forthcoming; Pomerantz, Gill & Denvir, 2007; Stivers, 2002). However, this research has been based on history taking aimed at diagnosing acute medical problems, not routine history taking aimed at developing/updating a broad picture of a patient’s health status and history. Patients who have been reasoning through their acute problems at home may feel more prepared and entitled to share their own diagnostic ideas when they present them during a medical visit.
2. history of smoking?
3. (.)
4. Pat: No.
5. (1.0) ((Physician typing on laptop))
6. Doc: Drinking?
7. Doc: °Alcohol?°
8. (.)
9. Pat: °Not a lo:t;°

In line 9, the patient responded to the physician’s alcohol use query (lines 6-7) by providing an evaluation of her alcohol use ("°Not a lo:t;°"). In offering this evaluation, the patient made a tacit claim of knowledge about what would constitute “a lot” of alcohol use and also tacitly proposed an entitlement to assess her own use with respect to that unspecified standard. By formulating her response as a negation of a potentially problematic state of affairs the patient cast her own use as normal or unproblematic. At no point did she provide any numerical information for the physician to evaluate. The patient treated her own evaluation as an adequate and complete response to the physician’s query. In doing so, the patient displayed health consciousness, one aspect of character. Not only did she cast herself as well informed about the standards for healthy alcohol consumption, she described herself as drinking appropriately within those standards.

Case 8: A0813|1.22|"Blue Moon"

1. Doc: D’you drink alcohol?
2. (0.2)
3. Pat: °Once in a blue moon?
In line 3, the patient employed an idiomatic expression to portray her alcohol consumption as highly infrequent (“Once in a blue moon?”). In using an idiomatic expression of quantity/frequency, the patient invited the physician to see her response not as indicating any specific numerical information, but rather as a gloss for minimal alcohol consumption. The patient did not provide any real numerical information for the physician to evaluate; she provided her own evaluation of her use as minimal and thus unproblematic. As in the previous case, the patient cast herself as competent to determine that her alcohol use is well below whatever guidelines might be relevant for a medical history. Rather than providing an informational estimate and allowing the physician to conclude that this represented minimal use, she asserted this herself. In that sense, the patient displayed health consciousness.

For the next instance, I return to Case 4, which I had previously analyzed in terms of the patient’s marked denial of drug use and her detailing the type, quantity, and frequency of her alcohol use. Here, I address the categorical evaluation she employed in her report on alcohol use.

Case 4: A0718(2)|3.10|"Not a Heavy Drinker"

1. Doc: Are you a drinker?
2. (0.2)
3. Pat:→ pt I drink beer every now an’ then. I’m not a
4. → (0.2) heavy drinker not like that=maybe once (‘n)
5. a while on the weekend I’ll have a couple er

10 This patient is from Jamaica and has a fairly pronounced accent. The intonation marker at the end of her utterance (?) is meant to capture an aspect of her accent. She did not appear to deliver this utterance with interrogative intonation.
In lines 3-4, the patient evaluated her own alcohol use by reference to an identity category that implies problematic drinking (“I’m not a (0.2) heavy drinker not like that”). In evaluating her own use as not constituting heavy drinking, the patient made a tacit claim of knowledge about what ‘heavy drinking’ means and an entitlement to evaluate her own use as falling below that standard. Unlike the previous two cases in this subsection, this patient also provided more specific information about the type, quantity, and frequency of use, allowing the physician to independently assess its status. Nonetheless, in providing her own evaluation first, the patient provided for this to be heard not just as information, but as evidence that she is not a heavy drinker. In that sense, the patient made the case that she was health conscious about her drinking behavior. She displayed an investment in resisting a category of drinking that might call her character into question.

Section 2: Physicians’ (Limited) Support for Patients’ Enactment of Strong Character

Physicians generally appeared to be quite limited in their involvement in patients’ enactment of strong character. In the conclusions chapter, I consider a range of possible explanations for this. While my overarching finding is that physicians did not openly collaborate in managing patient character, there were two potentially character-implicative aspects of their conduct worth noting. First, physicians almost never followed up when a patient initially framed his/her conduct as normal or unproblematic. Second, physicians provided hearings that helped to surface the evaluative case the patient was making.
Physicians Almost Never Followed Up When a Patient Initially Framed His/Her Conduct as Normal or Unproblematic

Physicians generally treated patient’s responses as sufficient and appropriate to advance the history, even though they departed in some ways from the minimal, information-centric response types used in other parts of a routine history. They did this by employing standardized receipt terms (e.g. “Okay.”), making entries in the patient’s EMR, or initiating a next query or topic, all of which signaled that the patient’s response had relevantly advanced the history. Physicians very rarely provided a follow-up query when patients portrayed their lifestyle conduct as normal, appropriate, or desirable. The following cases exemplify physicians’ typical responses in such cases:

Case 1: A0803|8.30|"Not A Lot"

1. Doc: Drinking?
2. Doc: "Alcohol?"
3. (.)
4. Pat: "Not a lot;"
5. → (1.2) ((Physician typing on EMR))
6. Doc: Drugs,=>marijuana cocaine [hero-< ]
7. Pat: ["Na::h°]
8. → (0.7) ((Physician typing on EMR))
9. Pat: "Na:h°
10. Doc: A::nd (. you are married?

Case 2: R1025|7.22|"College Drinking"

1. Doc: Any history of uh drug use.
2. Pat: Naw:: >"I don’t use any drugs"<
In the medical education and training literature, more thorough and detailed histories are generally recommended (Clark, 1995). For example, physicians are encouraged to query patients specifically about drug use in the past, as patients may assume that only their current conduct is relevant to report. In my data, just one physician did this in just one case (discussed in analytic chapter 2). Other research (Taj, 1998) has shown that a single query about binge drinking within the last year (diplomatically designed) is a reasonably efficient and reliable way to identify problem drinking. In my data, no physicians queried patients about heavier episodic drinking (i.e. binge drinking) within their normal routine of limited, occasional drinking. In the conclusions chapter I consider some explanations for these patterns, but here my point is only that physicians treated patients’ ‘special’ responses as appropriate and sufficient for the information seeking purposes at hand. They did not dig deeper in the ways that medical literature has suggested.

This could be seen as supportive of character in two ways. First, in those cases where patients made tacit claims of expertise or entitlement to evaluate their own conduct, physicians implicitly ratified those claims by treating them as appropriate. In that sense, physicians supported patients’ claims to health consciousness. Second, when
physicians elected not to follow up with secondary queries about past drug use or heavier episodic drinking, they could be seen as respecting patients’ portrayals of their lifestyle. If a physician were to immediately follow a patient’s claim of infrequent drinking with another query about drinking, it might be heard as skeptical or even accusatory. But by treating their responses (especially those patient evaluations that contained no actual information) as accurate and complete, physicians displayed respect for patients’ integrity and trustworthiness, two other features of Goffman’s concept of character.

2. Physicians Provided Hearings That Helped to Surface the Evaluative Case the Patient Was Making

Physicians employed one practice that more explicitly supported patients’ enactment of evaluative stances, though it was used in only two instances. This practice involved physicians’ producing a hearing (or version) of what the patient had just reported, a slot typically reserved for fairly minimal displays of receipt (see above). It is with respect to the typical pattern of minimal receipt that these hearings stood out as accomplishing more than simple receipt. I argue that these hearings helped to subtly surface what the patient was tacitly claiming in his/her report, namely that his/her conduct is normatively appropriate.

Case 3: A0718(1)|7.51|"Drugs in Your Whole Life"

1. Doc: An’ [did you] ever do drugs in yer whole lif:e,=
2. Pat: [W- w-]

In line 4, before the patient had even completed her elongated response, the physician receipted her response by providing a hearing or interpretation of it (“Nothing
at all.”). The physician’s formulation displayed her understanding in very strong terms that the patient had never used drugs of any kind. This could be seen as an “extreme case formulation” (Pomerantz, 1986) of the absence of drug use. Her terminal intonation also framed this very clearly as a hearing, not a request for further confirmation. Compared with the standardized receipts in the above cases, this physician could be seen as providing a ‘matched’ marked receipt of the patient’s marked ‘no-type’ response, one that displayed awareness of the special interactional work that the patient was doing. The physician collaborated in the patient’s portrayal of her drug use conduct by surfacing what was implicit in the patient’s response.

Case 7: A0718(3)|9.39|"Quick Sub History"

1. Doc: U:m:, (0.2) pтуh (. ) alcohol.
2. (0.7)
3. Pat: pтуh ↑U::m ↑couple glasses uh wine a week.
4. Doc: °°Okay.°° ((Physician writing in chart))
7. Doc: And drugs.

In line 4, the physician receipted the patient’s report with a soft “°°Okay°°” and made an entry in her paper chart. Even though she had already signaled receipt, the physician then provided the hearing, “°°Occasional.°°” to describe the patient’s alcohol use. The physician might also have been indicating that she had entered ‘occasional’ in the patient’s chart. This term was quite common in these data and was used by both physicians and patients to convey a normatively appropriate pattern of substance use. By
‘translating’ the patient’s report into this standardized term for appropriate use, the physician subtly supported the patient’s portrayal of her alcohol use as unproblematic.

A final point about physician’s involvement in the enactment of patient character is that the two activities I described did not require any exotic behaviors on the part of physicians. Rather, physicians appeared to maintain an orientation to their situated identity as physicians and the behavioral repertoire that was relevantly available to them during history taking. Displaying understanding and/or receipt is an utterly role-appropriate activity for incumbents of the physician role, but during lifestyle history taking, these resources can be deployed in ways that subtly support the ‘special’ interactional work that patients appear to be doing.

Summary

In this chapter, I argued that patients’ responses to routine lifestyle queries departed in some ways from the typical responses observed in other parts of a comprehensive medical history. Rather than providing minimal, fitted, information-oriented reports, patients’ responses served to enact evaluative stances toward their reported lifestyle conduct, tacitly making the case that their conduct should be understood as normal, unproblematic, or even desirable.

I argued that this work appeared to be motivated at least in part by concerns about enacting strong character. I employed a notion of character that included the traditional socio-moral aspects that Goffman discussed (self-respect, self-discipline, integrity, etc) as well as the concept of health-consciousness, an attribute that I framed as an application or extension of Goffman’s initial notion of character. While my emphasis was on character, I also argued that patients appeared to display a concern with appropriately fulfilling the
obligations of their situated identity as patients, which meant providing responses that relevantly addressed the physician’s query and allowed the history to progress as accountably complete. In short, patients did not ‘step out’ of their situated identity in order to address character; they wove character-enhancing features into responses that were largely consistent with that identity. I described and illustrated three interactional practices that patients used to accomplish this identity work, all of which implicitly traded on shared cultural knowledge about lifestyle and health.

I also argued that physicians were largely uninvolved in patient character; there was little evidence that physicians explicitly or implicitly registered the character-enhancing aspects of patients’ responses. However, I did describe and illustrate two interactional practices for receipting information that could be seen as subtly supportive of patients’ enactment of strong character. Like patients, physicians did not appear to ‘step out’ of their physician role to do so (e.g. “Okay, in terms of drug use, it sounds like you’re making good choices.”). Rather, their receipting activities were ostensibly consistent with what physicians ought to be doing during routine history taking.
ANALYTIC CHAPTER TWO:
THREATS TO CHARACTER AND RESTORATION OF CHARACTER

Identity and Identity Management: How Am I Using These Concepts in This Chapter?

As in the first analytic chapter, the two aspects of identity that were most relevant and useful for explaining these data are situated identity and character. I use these aspects of identity in much the same way in this chapter. However, the patients in these cases appeared to be engaged in a different sort of identity management project than those patients presented in the previous chapter.

In that chapter, I examine cases in which patients responded to routine lifestyle queries by enacting evaluative, ‘no problem’ stances toward their conduct. I argue that these activities were designed in part to enact strong character, to invite the inference that the patient is a morally and/or medically appropriate person, unspoiled by troubles in the delicate domains of lifestyle. In this chapter, I examine cases in which patients were arguably doing just the opposite. That is, in response to the same sorts of routine lifestyle queries, patients sometimes responded in ways that forecasted, proposed, or acknowledged that there had been something potentially problematic about their lifestyle conduct or circumstances. Whereas patients in the first chapter provided character-enhancing framings of their conduct, patients in this chapter provided character-threatening ones, at least in their initial responses to physicians’ queries. It should be stressed that both character-enhancing and character-threatening framings of conduct are alternatives to responses that simply provide information in the minimal formats typical of routine history taking. In employing either framing, patients were doing more than what was required for the informational purposes at hand. As with the first chapter, this
chapter offers an account for some of the ‘special’ interactional work in which patients were apparently engaged.

When patients produced character-threatening initial responses, this provided for the relevance of a different sort of identity management project: the restoration of character. As I have noted, identity management can be about claiming or projecting a desirable identity, but it can also be about resisting an undesirable identity. In these cases, patients appeared to display a concern with the identity inferences that might be drawn from the problematic information they were reporting and took steps to resist the “worst possible readings” (Goffman, 1971, p. 108-109) of that information. A primary goal of this analysis is to describe the interactional practices through which patients resisted these readings and, in so doing, worked to restore their character.

From a certain perspective, this identity management project could be seen as somewhat puzzling. On the one hand, patients themselves provided character-threatening information and, more importantly, did so in ways that proposed or acknowledged the problematicity of what they were reporting. On the other hand, they worked to restore the ‘damage’ that they themselves had more-or-less voluntarily done. Understood solely in terms of character concerns, this project might seem counterproductive, even incoherent. However, when we include the notion of situated identity -- specifically the patient role -- this project begins to make more sense. In the first analytic chapter, I argue that patients’ enactment of strong character exhibited sensitivity to the behavioral expectations of the patient role; these expectations operated as a kind of constraint on the repertoire of
character-enhancing activities available to the patient\textsuperscript{11}. When patients present information as problematic, they can be understood as observing another constraint of the patient role: the obligation to provide information that is accurate enough to enable the physician to appropriately evaluate and/or treat them. Roughly speaking, this means ‘telling the truth’ even when it might be unflattering in some respects. Thus, the somewhat puzzling or contradictory aspects of patients’ conduct in these cases could be understood in terms of their managing countervailing identity concerns. Concerns about fulfilling the reporting demands of the patient role account for their supplying character-threatening information, while concerns about character account for their working to resist the negative inferences that might be drawn from that information.

What Did Threats to Character and Restoration of Character Look Like Empirically?

Threats to Character

Patients employed a few different interactional practices that served to frame their lifestyle conduct as potentially problematic. Some practices were fairly explicit, such as one case in which a patient acknowledged that his alcohol consumption might be interfering with his blood pressure medication. Other practices were more implicit, such as those cases in which patients delayed the production of the problematic information. Whether performed explicitly or implicitly, when patients framed their conduct as problematic, I argue that they produced the ‘raw materials’ from which undesirable inferences about character might be made.

\textsuperscript{11} For example, the use of indirect or implicit interactional practices could be attributed in part to the patient’s obligation to maintain an on-record orientation to the history taking activity, specifically the need to not derail that time-consuming activity with elaborate or defensive forms of identity management.
Restoration of Character

Similar to the enactment of strong character, the restoration of character involved fairly indirect or implicit interactional practices of identity management. These included various types of disclaimers, mitigations, and contextualizing moves that portrayed the patient as normal, moral, reasonable, responsible, health-conscious, etc. despite the fact that the specific conduct in question had not been fully consistent with these qualities. Not surprisingly, some of the practices for restoring character overlap with the practices for enacting strong character discussed in analytic chapter one. For example, in both chapters the subtle minimization of quantities/frequencies of conduct (e.g. the number of drinks or of sexual partners) were employed. Other practices were unique to the project of restoring character, such as the minimization of personal agency in problematic conduct. In all cases, the character-restoring dimensions of patients’ talk tacitly relied upon shared cultural knowledge about health and lifestyle.

Organization of the Analysis

This chapter is organized in two main sections. In the first section, I describe and illustrate four interactional practices that patients used to restore their character. I regard these as the primary findings of this chapter. In the second section, I describe and illustrate physicians’ responses to patients’ efforts to restore character. While I ultimately argue that physicians generally appeared to be uninolved in the restoration of patient character, I describe a single interactional practice that was supportive of this identity management project.
Section 1: Patients’ Practices for Restoring Character

The practices described in this section are: (1) Displaying independent awareness that reported lifestyle conduct is problematic; (2) Mitigating personal agency in problematic lifestyle conduct; (3) Framing problematic conduct as ‘in my past’ or already resolved; (4) Employing quantity or frequency formulations that downplay the magnitude of problematic conduct.

1. Displaying Independent Awareness that Reported Lifestyle Conduct is Problematic

It should be stressed that, in referring to lifestyle conduct as ‘problematic,’ I am relying on patients’ own displayed orientations to their conduct as problematic, not my own personal judgments. It is significant that patients themselves did the work of framing their conduct in this way and I argue that this can be seen as restorative of character. This may seem counterintuitive. How could it be restorative of character to frame one’s conduct as problematic? Goffman’s (1971) notion of “splitting the self” provides a useful rationale. In his discussion of different strategies for remediation, he claims that, “apologies represent a splitting of the self into a blameworthy part and a part that stands back and sympathizes with the blame giving, and, by implication is worthy of being brought back into the fold” (p. 113). He argues that variations of “splitting the self” are also evident in other types of remediation, such as accounts, where the speaker splits the self into a temporary part that was constrained by circumstances and an enduring part that, if freed from those constraints, would have done something better. In splitting the self, a speaker acknowledges the problematicity of his or her actual conduct, while at the same time displaying awareness of, and allegiance to, the normative expectations that have been violated. This is the sense in which the speaker is “worthy of being brought
back into the fold.” When patients frame their lifestyle conduct as problematic, they display an awareness of the normative standards by which their conduct could be evaluated and show that they can independently acknowledge a possible violation. They show themselves to be normatively compliant in thought, if not always in deed.\(^\text{12}\)

In this subsection, I describe and illustrate three practices that patients used to frame their conduct as problematic. They are: (i) Enacting evaluative stances toward reported lifestyle conduct; (ii) Invoking a medical concern related to lifestyle conduct; (iii) Delaying a report of problematic conduct.

(i) Enacting Evaluative Stances Toward Reported Lifestyle Conduct.

In enacting evaluative stances, patients displayed an independent understanding of how their conduct might be evaluated. They showed themselves to be properly oriented to the normative standards or expectations that may apply, even as they cast themselves as possibly violating those standards in their actual conduct.

In Case 1, the patient reported how many lifetime sexual partners he has had (15-20) and then expressed regret about this number. He implied that there was something problematic about this information.

Case 1: R1025|8.00|"HIV Test Hard Sell"

1. Doc: How many lifetime sexual partners do you have.
2. Pat: \(\text{.h (0.5)}\) \text{U:mhh }\text{u::h that’s a big one huh, HEH HEH}

\(^{12}\) Another function that this practice may serve is forestalling the physician’s pointing out that this conduct is problematic. To the extent that a patient is already displaying awareness that his or her conduct is problematic, it may be less necessary for the physician to “pile on.” This too can be understood in terms of identity management, as it works to pre-empt a circumstance in which the patient is positioned as a person who is ignorant of the fact that his/her conduct warrants reprimand or intervention.
In lines 6-7, the patient, a 33-year-old Caucasian male, reported that he had had approximately 15-20 sexual partners in his lifetime. In line 8, the physician initiated another query, but abandoned his turn when the patient spoke again in overlap (line 9). In lines 9-10, the patient indicated that he viewed this number as potentially regrettable. In the context of a sexual history, an ostensible basis of regret would be that this number of sexual partners could have put him at higher risk for sexually transmitted infections. It is also possible that the patient was proposing that this number of sexual partners represents a normatively inappropriate level of promiscuity. Both hearings could be seen as character implicative, in that they imply a lapse in health consciousness or moral bearing. The physician’s query in line 8 (at least the portion that was hearable by the patient) did not orient to the patient’s prior report as problematic. It was the patient who introduced the relevance of evaluating his number of sexual partners even as the physician continued to gather additional information in line 8. In employing the tag “right” (“[ I] prob’ly regret that now right,=hhhh[h]”), the patient indicated his expectation that the physician would align with this evaluation. In doing so, the patient didn’t simply evaluate his own conduct; he positioned himself as voicing an evaluation that the physician, a
representative of medical knowledge and authority, might make. In framing his conduct as ‘regrettably’ discrepant with these standards, the patient tacitly proposed his basic endorsement of them. To the extent that his actual history might suggest otherwise, the patient’s evaluative stance implied that he is now appropriately oriented to these standards. This served to restore character in an environment in which he had provided the ‘raw materials’ for unpredictable and possibly undesirable inferences about character.

The patient showed interactional initiative in enacting this evaluative stance. After the patient’s report, the physician produced another query (line 8), signaling adequate completion of the previous query-response sequence. Prior to the physician’s completing his query, the patient spoke in overlap, reclaiming the floor to provide his ‘regret’ utterance in lines 9-10. It is possible that the patient was initiating this utterance earlier in line 9, but abandoned it in overlap with the physician’s query. By speaking in overlap and effectively interrupting the physician’s bid to continue gathering information, the patient displayed some investment in getting his regret heard. While we cannot be sure what motivated his initiative, in my view this lends support to the idea that the patient is engaged in a project beyond simple information transfer.

In Case 2, the patient treated her lack of current sexual partnerships as an accountable matter, while also proposing that things are turning around for her on that front.

Case 2: A0718(3)10.13"There’s Hope"

1. Doc: D’you ‘ave any pe:\ts:.
2. Pat: Nope.
3. (3.0) ((Physician writes in chart))
5. Pat: =Nope.

6. (2.7) ((Physician writes in chart))

7. Doc: °Okay°=Are you sexually active?

8. (.)


10. (1.7) ((Physician writes in chart))

11. Doc: So n[° ( )]

12. Pat:→ [Though there’s] hope.=Heh

In line 4, the physician asked the patient if she lived with anyone. The patient, a 45-year-old Caucasian female, indicated that she does not (line 5). In line 7, the physician asked if the patient is sexually active and the patient indicated that she is not (“No.” in line 9). The physician made an entry in the patient’s chart (line 10) and then began what appeared to be a related follow up query in line 11 (the turn-initial “So” implies a link with the prior query-response sequence). In line 12, in partial overlap with the physician, the patient provided an additional detail about her circumstances (“Though there’s hope.=Heh”). The patient may have been indicating that she has recently found a prospective sexual partner or that she simply has a hopeful outlook about finding one. In either case, this additional detailing served to treat her prior response as warranting some form of expansion or repair.

When speakers engage in repair, the lay assumption is that they do so in order to address potential problems with a prior utterance (Schegloff, Jefferson & Sacks, 1977). Repairs can be analyzed in terms of the problem(s) that the speaker is demonstrably working to address. In this case, the patient’s expansion in line 12 treated her previous response as having painted a somewhat bleak picture of her romantic and sexual life
circumstances, particularly because she had also just reported living alone (line 5). These responses had furnished the raw materials with which to infer that she might be lonely, unattractive, sexually disinterested, etc. and these are understood culturally as rather undesirable. In her expansion, the patient displayed an orientation to these cultural understandings. By virtue of the turn-initial “Though,” she cast her current “hope” as contrastive with the circumstances she had just reported. Insofar as there is now hope, the patient tacitly suggested that her previously reported circumstances were evaluable as “hopeless” (or less hopeful). In this sense, the patient oriented to this aspect of her lifestyle as undesirable. She displayed her commonsense cultural awareness that what she was reporting could be seen as problematic, a source of sadness or concern.

For Goffman (1967), character involves qualities of courage and “gameness” (p. 218), the ability to persevere despite setbacks. To the extent that her lack of partnerships could be seen as a sign of resignation or withdrawal from intimate companionship, this portrayal of her lifestyle was character implicative. In claiming that there is now hope, the patient displayed gameness and thus restored her character.

The patient showed interactional initiative in appending her previous response. This sequence (or at least the query-response adjacency pair) was apparently complete in that the physician had made an entry in the chart and started up another query. This is a somewhat inhospitable interactional environment for providing an expansion, particularly in the relatively restrictive activity context of routine history taking. The patient also spoke in overlap with the physician’s next query, displaying a measure of investment in voicing this additional detail. Again, this initiative lends support to the claim that these patients were working on some sort of project beyond passively answering questions.
The next case is somewhat different from the previous two cases in that the patient was not responding to a specific query from the physician. While most routine medical histories are structured around sequences of physician initiated, closed-ended queries and responses, this physician-patient dyad was more conversational, with the patient initiating many topics and volunteering many updates without specific prompting by the physician. This may be related to the fact that this was an annual checkup visit, not an initial visit. The patient may have felt more comfortable asserting herself by virtue of their relational history or by virtue of her familiarity with the topics that the physician would likely cover. Although the structure of this history is somewhat atypical, the patient still enacted an evaluative stance when reporting on her lifestyle conduct, treating it as problematic.

Case 3: K0921|33.45”Drinking After Work”

1. Pat: So but I have I have been b- making a conscious
2. effort (. ) tuh eat well.
3. (. )
4. Pat: A:nd um .hh I: uh for a whi:le I think I was
5. drinking too much an’ I just ((quickly
6. shaking head no)) (. ) s’rt of (. ) do:n’t.

In lines 4-5, the patient described a recent period of drinking “too much.” In employing the formulation “too much,” the patient implicitly cast her conduct as discrepant with some standard for appropriate drinking. This could be seen as character threatening both in terms of a lapse in health consciousness and an abrogation of restraint or self-discipline. By including the epistemic marker, “I think” (line 4), she framed this as a product of her own judgment and perspective. She cast herself as competent and even-
handed in her orientation to the standards by which her conduct could be evaluated. Even though she had not been fully compliant with those standards in her actual conduct, she cast herself as aware and appropriately oriented to them. By tacitly proposing allegiance to these standards, the patient restored character in the face of information that might suggest otherwise.

(ii) Invoking a Medical Concern Related to Lifestyle Conduct.

Another way in which patients cast their reported lifestyle conduct as problematic was to associate it with a health problem or concern. In framing one’s lifestyle conduct as possibly producing or exacerbating a medical condition, a patient treats that conduct rather straightforwardly as problematic. This may be functionally similar to enacting an evaluative stance, but invoking a medical complication tied to lifestyle conduct provides a more explicitly medical basis for negatively evaluating one’s conduct.

In Case 4, a patient who is on medication that contraindicates alcohol use prefaced his report of increased wine consumption with a disclaimer that acknowledged its health consequences. The patient cast himself as having strayed from what he knows to be the more health conscious choice.

Case 4: R1004[9.56]"Pipe and Wine"

1. Doc: ((looking at laptop screen)) .h U::h (.) and then
2. in the past you told me (.) ((looking at
3. Patient))) only a gla__er two of wine on occa- on
4. occasion=Is that still about the same?
5. Pat:→ .hh (0.4) With the knowledge that I know: (0.3)
6. → that I’m not s’posed to drink any
7. → alcoho:[l, wi]th the medica- (.) w- I I don’t
In lines 1-4, the physician sought an update about the patient’s wine consumption, citing a previous report by the patient that he drinks “only a glass or two of wine on occasion.” This query did not cast the patient’s wine consumption as problematic or indicate any medical concerns about it. He applied the adverb “only” to the quantity of wine (“only a glass or two of wine”) and employed an idiomatic phrase for modest frequency (“on occasion”). Nonetheless, the patient responded in ways that treated his own conduct as potentially problematic.

In his initial response (lines 5-7), the patient did not provide the requested update. Rather, he expressed his understanding that any alcohol use is contraindicated while taking his medication(s). He later reported that he continued to drink wine, sometimes in larger quantities than he had previously reported (not shown in this transcript segment).
In initially employing a disclaimer, the patient projected that his subsequent report might be heard as problematic. The patient positioned his wine consumption as contrary to medical recommendations and as possibly compromising the effects of a significant prescription medication (blood pressure). He thus cast his wine consumption as an unhealthy behavior. However, by providing the disclaimer, the patient showed himself to be appropriately oriented to the status of his drinking. As Hewitt and Stokes (1975) argue, disclaimers are often deployed to manage identity concerns: “disclaimers seek to define forthcoming conduct as not relevant to the kind of identity-challenge or re-typification for which it might ordinarily serve as the basis. Examples abound and serve to make the abstract concrete: ‘I know this sounds stupid, but…’” (p. 3). Absent the disclaimer, the patient’s report might have furnished a basis for inferring that the patient is not health conscious. His disclaimer served to “split the self” into (a) a person who is taking a medical risk and (b) a person who is health conscious enough to know that he shouldn’t.

(iii) Delaying a Report of Problematic Conduct.

Previous research has shown that speakers may employ delays when producing a dispreferred (i.e. sensitive, undesirable, problematic) turn component (Pomerantz, 1984). In employing delay, speakers can forecast their own stance toward their forthcoming talk as problematic. Plainly speaking, delays can index that a speaker is ‘in no hurry’ to perform a projected action. Previous research on lifestyle history taking has identified this practice in patients’ reporting activities (Silverman, 1994; Weijts, Houtkoop & Mullen, 1993) and they were in evidence in these data as well. In general, physicians and patients collaboratively organize routine medical histories around rapid-fire sequences of
queries and responses. The distinctive closed-ended format of routine history taking provides for a high degree interactional efficiency. In this activity context, patients’ delays or perturbations in responding can be heard as more marked or salient than they might be in other activity contexts. That is, given the expectation of a crisp, efficient response, a delayed or turbulent response may suggest that some special interactional work is being done.

It should be noted that delays can be employed for various interactional purposes; not every delay functions to mark forthcoming actions or utterances as delicate or problematic. For example, speakers may delay a response to show that they do not understand a previous conversational action or that they are working to remember something relevant for responding. Thus, there is a danger in analyzing every delay in terms of dispreference. For the purposes of this analysis, I treat delays as secondary or supporting evidence that a patient was displaying an orientation to their reported conduct as problematic. In each of the cases I analyze below, there are other features that, when taken together, provide for the delays to be understood more convincingly in terms of dispreference.

In Case 5, the patient delayed his report of having used illegal drugs in the past.

**Case 5: F0928/4.09/”Not Writing”**

1. Doc: Any drug use,
2. (.)
3. Pat: No.
5. Pat:→ (0.7).hh U::h let’s [see here.]
6. Doc: [Not writing] mh mh mh [mh]
7. [((Physician lifts fingers from EMR))] 
8. Pat:→ [No] 
9. → um prob’ly I- (t-) I think I took u::h (.) back 
10. → in the early eighties it was uh occasional 
11. → marijuana,

Having already established in lines 1-3 that the patient does not currently use drugs, the physician queried the patient about past drug use in line 4. The patient did not immediately respond in line 5, leaving a gap of (0.7). When he initiated a turn, the patient produced an inbreath, an elongated “U::h,” and “let’s see here,” further delaying his report. 

In line 6, in partial overlap with “let’s see here,” the physician provided, “Not writing,” chuckling softly and lifting his fingers from the keys of his laptop (which contains the patient’s electronic medical record or EMR). The physician appeared to be jokingly assuring the patient that his response would be kept confidential or literally ‘off the record.’ In assuring the patient, the physician tacitly indicated that he was attributing the patient’s delayed response to his reluctance or discomfort about reporting drug use. The physician’s local interpretation nicely exemplifies the hearing of delay as an orientation to dispreference.

13 These features did more than just delay the patient’s report. They also displayed a mental search. In performing a mental search, the patient forecasted that he had at least some drug use to report, as someone who had never used drugs would likely not require a mental search just to say, “no.” A reasonable inference at this point is that the mental search involved remembering which drugs, in what quantities, at what times, etc. The present analysis, however, is focused primarily on the delay aspect.
The patient’s turn-initial “No” in line 9 rejected the physician’s interpretation of his initial delay, but he continued to employ various forms of delay before ultimately reporting marijuana use in line 12 (“u:m prob’ly I- (t-) I think I took u::h (.) back in the early eighties (I/it) was uh occasional marijuana”). This is a fairly turbulent utterance, with various fillers, dysfluencies, and restarts preceding the actual naming of the drug. This sort of difficulty in responding tacitly proposes that the patient now has the ‘proper’ orientation to illegal drug use as something problematic to report. He restored his character by framing his past drug use as something to report on reluctantly.

For the next instance I return to Case 1, which I previously analyzed in terms of the patient’s enacting a stance of regret toward his number of lifetime sexual partners.

Case 1: R1025/8.00"HIV Test Hard Sell"

1. Doc: How many lifetime sexual partners do you have.
2. Pat: .h (0.5) U:mhh u::h that’s a big one huh, HEH HEH
3. → [.hh]
5. (0.2)
6. Pat: I’ll say close to- close to: fifteen to
7. → twenty.=hh heh
8. Doc: Wh[at ] percent uh the ti[me]
9. Pat: [( )] [ I] prob’ly regret that
10. now right,=hhh[h]

In response to the physician’s query in line 1 (“How many lifetime sexual partners do you have.”), the patient did not immediately provide the requested report. Rather, he provided a somewhat cryptic remark about the query, topic, or information
being sought (“that’s a big one huh” in line 2). The patient may have been marking this as a significant topic or he may have been forecasting that the number of sexual partners he had to report was “big.” For the present analysis, I will simply note that this remark delayed his reporting the number of sexual partners that he ultimately framed as problematic (lines 6-7 and 9-10). When he actually produced the requested report in lines 6-7, he employed various forms of delay within the utterance. “I’ll say” and “close to” (produced twice, the second time with elongation on “to:”) function to mark the projected report as an approximation, but they also delay the production of the actual number, the turn component that is ostensibly the source of trouble. By displaying some reticence about producing this report, the patient may have been working to show his understanding that one’s number of sexual partnerships is culturally evaluable and that his specific number might be considered problematic. It might have portrayed him as promiscuous or risky in his sexual conduct.

For the next instance I return to Case 4, which I previously analyzed in terms of the patient’s employing a disclaimer that acknowledged the medical problematicity of his wine consumption. In this case, I address the disclaimer as part of a larger package for delaying the requested update in his wine consumption.

Case 4: R1004|9.56 "Pipe and Wine"

1. Doc: ((looking at laptop screen)) .h U::h (.) and then
2. in the past you told me (.) ((looking at
3. Patient)) only a glass er two of wine on occa- on
4. occasion=Is that still about the same?
5. Pat:→ .hh (0.4) With the knowledge that I know: (0.3)
6. → that I’m not s’posed to drink any
7.  $\rightarrow$ alcoho:[$l$, wi]th the medica- (. ) w- I I don't
8. Doc:  [Yeah.]
9. Pat:  $\rightarrow$ remember which one it i:s=maybe it’s both,=

In addition to doing the work of disclaiming, a pre-positioned disclaimer serves to
delay the subsequent action or utterance to which the disclaimer applies. In this case, the
patient’s disclaimer in lines 5-7 delayed his reporting that he continues to drink wine,
pushing that report back until later in the sequence (not shown in transcript). This also
provided for that subsequent report to be heard in light of his having already
acknowledged that drinking is contraindicated while on his medications. The patient’s
working to remember which medications were relevant (lines 7 and 9) served to further
delay the problematic report. The disclaimer itself was also preceded by some delay, as
the patient employed a turn-initial inbreath and a pause of (0.4). This is not an
exceptionally long delay, even in the context of routine history taking, but upon the
production of the disclaimer, the physician could retrospectively analyze the initial delay
as having projected this special interactional work.

In Case 6, a patient employed a relatively pronounced delay in reporting his
wife’s marital infidelity. In terms of character, this case is quite different from the others
in this collection. Exactly whose character might be at stake here?

Certainly there could be concerns about the inferences that may be made about
the wife’s character. While marital infidelity is a very complex phenomenon, my sense is
that it is understood culturally as a lapse in integrity (trustworthiness, restraint, self-
discipline), which Goffman proposes as one of the more culturally universal aspects of
character. It may be that certain social pairings, such as intimate partnerships or parent-
child dyads, prompt individual members of those pairings to engage in identity
management on behalf of the other members, where the rationale is that the actions of one member are thought to reflect on the standing of the pair as a whole. Goffman’s notion of “performance teams” (1959, p. 79) suggests as much, and in fact he used husband-wife teams as the paradigm example. This is one way to understand the character-restoring activities of an ostensibly ‘innocent’ person.

Another way to understand this is to see the patient’s individual identity -- his character -- as threatened by his wife’s infidelity. Goffman’s notion of character does not provide especially useful terms for making this argument, but perhaps the self-respect component of character is most apt for this case. In staying with his wife after she caused him pain, anger, humiliation, etc., he risks portraying himself as weak or dependent, a pushover who lacks self-respect. Ultimately, it is difficult to say with much certainty what sorts of identity concerns the patient may have been orienting to with his delayed report. I have provided two possibilities that can help to explain a response that, absent such concerns, should have been a simple and immediate, “No, she had an affair.”

Case 6: F0928/6.46|”Sex Outside Marriage”

1. Doc:  And _any_ sex outside the marriage.
2. Pat:  No. hhhh[hh ]
3. Doc:  [No,] ((Physician typing))
4.  (0.7)
5. Doc:  °‘Kay°

14 On the other hand, he could be seen as exemplifying gameness, an aspect of character that speaks to perseverance in the face of setbacks. Thus, the same behavior could be interpreted in ways that are both character enhancing and character threatening, depending on which aspects of character serve as the local interpretive resources. In the conclusion chapter, I consider some limitations of the character concept along these lines.
In lines 7-8, the physician asked if the patient’s wife had been monogamous. The patient’s response was marked by substantial delays, including an initial gap of (1.2) an elongated “U::h,” and another gap of (0.9). These delays powerfully forecasted that the patient would report some infidelity. Moreover, they served as a resource for the patient to display his orientation to marital infidelity as problematic. Had the patient presented this information in a matter-of-fact manner, he likely would have appeared enormously insensitive to the cultural meanings associated with infidelity. By presenting it as difficult or problematic, he displayed an appropriate orientation to the infidelity.

In this subsection, I described and illustrated three practices that patients used to frame their conduct as problematic: (i) Enacting evaluative stances toward reported lifestyle conduct; (ii) Invoking a medical concern related to lifestyle conduct; (iii) Delaying a report of problematic conduct. I argued that these practices can be understood as subtly restorative of character in that they propose an awareness of, and basic allegiance to, the normative standards that their actual conduct may have violated. While these activities sometimes lengthened or mildly disrupted the orderly flow of information exchange, it did appear that patients maintained an overarching orientation to their
situated patient role and its attendant obligations to provide accurate information in a relatively efficient way. The management of character never appeared to be the primary interactional business; it was largely woven into the ongoing history taking activity framework.

2. Mitigating Personal Agency in Problematic Lifestyle Conduct

Many aspects of illness and wellness are understood to be beyond one’s control. For example, catching a contagious illness (e.g. influenza) or developing a condition to which one is genetically predisposed (e.g. migraine headaches) are understood in commonsense terms as acting upon that person from some external locus of control (i.e. they happen to that person). Lifestyle matters are somewhat unique in this regard. They are understood more in terms of a patient’s volition, his or her everyday choice making or conduct. Because lifestyle topics speak to the basic healthiness or unhealthiness of everyday habits and choices, they are arguably fertile ground for concerns about health consciousness. One way in which patients addressed this concern was to mitigate or downplay their own personal agency in their reported conduct. In mitigating personal agency, patients resisted the appearance that they voluntarily, unilaterally, or knowingly exposed themselves to health risks.

For the first instance I return to Case 3, which I previously analyzed in terms of the patient’s acknowledging that she had been drinking too much. As the sequence continued, the patient provided additional details about the circumstances of her drinking.

Case 3: K0921|33.45|”Drinking After Work”

1. Pat:     A:nd um .hh I: uh for a whi:le I think I was
drinking too much an’ I just ((quickly shaking
3.     head no)) (. s’rt of (. do:n’t.)
4. ((Physician looks up from laptop))
5. Pat: Y’know I might have couple beers an’
6. th[at’s all.]
7. Doc: [Drinking ] alcohol t[oo much,]
8. Pat: [ Yea:h ] [but]
9. ((17 lines omitted))
10. Doc: ((pointing at Patient)) [There’s a] lotta’
11. calories in it.
12. Pat: Oh I know there ar- I do ((patient points at
13. → physician)) dri(h)nk li(h)ght bee(h)r bu t .hh ↓no
14. → and(h) no: I jus:t (1.7) I- uh- people from work
15. → go out after work an’ that’s how y’get sucked
16. → into the whole .hh y’know. pt (0.2)
17. Doc: R- glass uh red wine very good for you.

In the 17 lines omitted in line 9, the physician and patient had discussed in a somewhat jocular fashion the possibility that the patient’s recent weight gain was tied to her drinking too much. In lines 10-11, the physician indicated that beer, the patient’s preferred drink, is high in calories. In lines 12-13, the patient reported that she knows this and that she drinks light beer. Although my primary emphasis here is on the agency implications of her subsequent talk, it is worth noting that the patient’s assurance that she drinks light beer was also restorative of her health consciousness. In an environment in which the physician had implied a connection between her drinking and weight gain, the patient indicated that she had taken steps to limit this health consequence.
Using transition markers (“↓ no and(h) no.”), the patient then shifted to a somewhat different aspect of her drinking, the circumstances in which she drinks. In lines 14-16, she described her going out with colleagues after work (“I just (1.7) I- uh- people from work go out after work an’ that’s how y’get sucked into the whole .hh y’know. pt (0.2)”) Several aspects of this description served to mitigate her agency in her drinking behavior. First, she attributed the primary initiative to go out for drinks to her colleagues (“people from work go out…”), thus tacitly framing herself as ‘tagging along’ in their activity. In specifying that these are “people from work” and not, for example, “friends” or just “people,” the patient subtly invited the inference that these outings have a collegial dimension, where not participating may have informal consequences for her standing in her professional circles. This framed her drinking after work as not fully voluntary.

Second, the patient claimed to have been “sucked into” her recent pattern of drinking, a formulation that portrays her as an unwitting casualty of perilous circumstances rather than a choice-making agent. Third, the patient generalized (and thus depersonalized) her circumstances by using the pronoun “you” (“y’get sucked” in line 15). Rather than reporting, “that’s how I got sucked into…” the patient framed her circumstance as an instance of a more commonplace pattern, something that happens to everyone. In so doing, she diminished the relevance of her own particular choice making.

In reporting that she had been drinking too much, the patient provided the ‘raw materials’ for inferences about her character, both in terms of health consciousness and self-discipline. But by subsequently mitigating her own agency in producing these circumstances, the patient worked to restore her character.
For the next instance I return to Case 5, which I previously analyzed in terms of the patient’s delaying his report of marijuana use. As the sequence continued, the patient reported that he had also used speed. In describing his use of both drugs, the patient mitigated his own agency.

Case 5: F0928|4.09|"Not Writing"

1. Doc: Any drug use,
2. (.)
3. Pat: No.
5. (0.7)
6. Pat:.hh U::h let’s [see here.]
7. Doc: [Not writing] mh mh mh [mh]
8. Pat: [No] u:m
9. prob’ly I- (t-) I think I took u::h (. ) back in
10. → the early eighties it was uh occasional
11. → marijuana,
12. Doc: Okay,
13. Pat: And u:h .hh (he) told me it was speed (. ) but
14. → that was prob’ly three er four times.
15. Pat: N’that was prob’ly eighty: one (m)eighty
16. tw[o.]
17. Doc: [Or]al?

In line 13, the patient invoked an unnamed third party who apparently provided him with speed (“(he) told me it was speed”). In treating this as uncertain, second-hand
information, the patient downplayed his own epistemic authority regarding this drug use. In combination with his subsequent report of having used speed only “three er four times,” (line 14) the patient cast himself as something of a novice outsider to speed use, someone who was dabbling in the unfamiliar. In terms of agency, the patient portrayed himself as a passive recipient of someone else’s speed, not as actively seeking out speed. This was restorative of character in that it resisted the identity of ‘speed user’ in favor of something closer to, ‘speed experimenter.’

Certain syntactic features in the patient’s responses also subtly mitigated his agency in using drugs. The patient formulated his responses without ever producing a straightforward and complete subject + verb + object locution (for example: “I smoked marijuana”). This type of formulation could be seen to maximize agency, explicitly casting the speaker as the active agent in a potentially problematic activity. In line 9, the patient did initiate such a formulation (“I took”) but rather than completing the utterance, he provided an elongated “u::h,” a micropause, a syntactically parenthetical phrase (“back in the early eighties”), and then initiated a different subject + verb + object phrase (“it was uh occasional marijuana”), that was syntactically disjunctive with the now abandoned locution “I took…” All of this interceding talk served to subtly disengage the patient-as-subject from the act of smoking marijuana. In line 14, the subject + verb + object locution was essentially elided by the pro-term “that,” (“that was prob’ly three er four times”) where “that” stands in for something like “my taking speed.”

It should be noted that in these data, patients did employ straightforward subject + verb phrases to refer to their cigarette use (‘I smoke…’) and alcohol use (‘I drink…’). Given its illegality and relative normative deviance, it may be more difficult for patients
to employ such formulations to report on their drug use. I do not have enough cases of reported drug use in this collection to explore this possibility, but this case is suggestive of some special difficulty in employing formulations that maximize one’s agency in drug use.

3. Framing Problematic Conduct as ‘In My Past’ or Already Resolved

During lifestyle history taking, it is appropriate for physicians to seek information about both current and past conduct. Past lifestyle conduct may have a bearing on patients’ current health status. For example, a history of intravenous drug use could expose a patient to a variety of health risks regardless of how long ago the use actually occurred. However, when patients report on problematic past conduct, they may work to have that conduct understood not just in terms of the chronological past, but as part of their ‘biographical past,’ the conduct of a person they used to be. By framing problematic conduct as ‘in my past,’ patients distance themselves from the identity attributions that may otherwise follow from their conduct. They also tacitly claim that the problematic lifestyle conduct has since been resolved and that their current circumstances are normatively appropriate. In several cases, this was accomplished by speaking in terms of ‘youthful indiscretions.’ This can be understood as a form of “splitting the self” into (a) a former self whose behavior may have been be problematic and (b) a present self who now sees the error of his/her ways.

For the first instance I return to Case 1, which I previously analyzed in terms of the patient’s initial delay in reporting his number of sexual partners and subsequent expressions of regret about that number. As the sequence continued, the patient provided additional details about the time period in which he had many partners.
Case 1: R1025[8.00]"HIV Test Hard Sell"

1. Doc:  How many lifetime sexual partners do you have.
2. Pat:  .h (0.5) U:mhh u::h that’s a big one huh, HEH HEH
3. [hh]
5. (0.2)
6. Pat:  I’ll say close to- close to: fifteen to
7. twenty.=hh heh
8. Doc:  Wh[at ] percent uh the ti[me]
9. Pat:  [( )][ I] prob’ly regret that
10. now right,=hhhh[h]
11.Doc:  [W]e'll d- I mean didja’ use
12. condoms?
13. ((25 lines omitted))
14.Pat:⇒ Yeah like (.) an’ that was: u:m (0.9) af- like my
15. ⇒ se:nior year an’ (.) after I graduated I’m like-
16. ⇒ an’ that was jus’ [(0.7)]
17.Doc:  [ Yup.]
18.Pat:⇒ That’s when I was: uh crazy but (.) y’know (.)
19. ⇒ pt.hh but I took no risk during my freshman
20. ⇒ sophomore an’ junior year=I was very ( ).

In the talk omitted in line 13, the physician and patient discussed the patient’s use of condoms, which had been somewhat inconsistent. The patient reported that he had
previously contracted genital warts. Both of these details arguably called into question the patient’s health consciousness. It was in that environment that the patient volunteered additional information about his past (lines 14-16 and 18-20). This information was not medically relevant in any obvious way, but did serve as character-restoring context for understanding the patient’s numerous partnerships, inconsistent condom use, and contraction of genital warts.

First, in lines 14-16 and 18 the patient invoked the relevance of a time period (senior year in college) in which he was engaging in high-risk behavior. The patient associated his contacting genital warts with this period of high-risk behavior, linking them through the pro-term “that” in lines 14-16 (“an’ that was u:m (0.9) af- like my se:nior year…”). Although he framed his conduct as problematic by using the characterization “crazy,” the patient also worked to indicate that this characterization no longer applies. His formulation in line 18 (“That’s when I was: crazy”) served to construct ‘temporal bookends’ around this period of problematic behavior. By casting this as a finite period of “crazy” behavior, one that can now be reported on with retrospective distance, the patient tacitly proposed that the issue has been resolved.

Second, the patient associated his “crazy” lifestyle with his late college years and transition into adulthood. The temporal markers “se:nior year” and “after I graduated” (line 15) called upon the physician to recognize the cultural relevance of this time period for understanding his risky behavior. In many cultures, one’s college years are understood as a time in which it may be more permissible to engage in risky conduct and this may even be understood as a normatively appropriate rite of passage (Workman, 2001). For many, the college lifestyle bleeds into the transition into adulthood. In
invoking this biographical time period, rather than using a chronological, “X years ago” metric, the patient displayed his expectation that the physician would share this cultural knowledge. The physician’s “Yup.” in line 17, which he provided before the patient had actually completed his utterance, indicated that he understood the cultural knowledge that the patient’s description was trading on.

Third, the patient indicated that he took “no risk” during his first three years of college (lines 19-20). This accomplished two things. First, it framed his later “crazy” behavior as an aberration from a previously established pattern of low-risk behavior. Second, it invoked the relevance of another aspect of cultural knowledge surrounding the college years, what is colloquially referred to as ‘senioritis.’ Senior year represents a student’s last chance to enjoy the freedoms of the college lifestyle, a last hurrah before ultimately entering into adult and professional responsibilities. The concept of senioritis generally implies light course loads, low levels of productivity or achievement, and high levels of social engagement. In reporting that he took no risks during his first three years, the patient portrayed himself as having dutifully denied himself these indulgences until this last year of college, the year in which it is perhaps most permissible to indulge. These details served to restore the patient’s character in an environment in which it might be in question.

Another case involving the same physician and patient, this one addressing alcohol use, illustrates a similar pattern. This sequence occurred about a minute before the prior sequence.

**Case 7: R1025|7.22|"College Drinking"

1. **Doc:** How much if any alcohol do you drink.
2. (1.2)
3. ((Physician looks up from EMR to Patient))

4. Pat: \(\rightarrow\) Not as much as I used to.

5. Doc: O[kay.]

6. Pat: [ So:] I mean, one or two beers a week.

7. Doc: 'Kay,= ((Physician writing in chart))

8. Pat: =If that.

9. (0.4)

10. Pat: En (.) when I go out maybe once a week I’ll have

11. maybe more than that but (0.4) hh that’s maybe

12. like twice ( ) [(at home)]

13. Doc: [ \(\overset{\circ}{\text{M hm}}\) ]

14. Pat: \(\rightarrow\) Na I don’t do it as much anymore< (. ) I used to

15. \(\rightarrow\) (.) when I was twenty-five, [((teethy inbreath))]

16. Doc: [Yeah (0.2) when yer]

17. \(\text{in college.}=\)

The patient did not respond immediately to the physician’s alcohol use query in line 1. The patient left a gap of (1.2) and didn’t respond until the physician looked up from the EMR and turned to the patient. As noted above, delays can serve as a resource for projecting the production of a dispreferred or problematic turn component. Given the patient’s eventual response in line 4 (“Not as much as I used to.”), this may have been what the delay was designed for. This report implied that the patient has some history of heavy alcohol use. However, it also indicated that the patient’s current alcohol use is less than it used to be, essentially trending in a more normatively appropriate direction. In
lines 6, 8, and 10-12, the patient provided more specific numerical information about his current alcohol use; he framed his current use as essentially normal and unproblematic.

In line 14-15, without any prompting from the physician, the patient returned to his past alcohol use (“Na I don’t do it as much anymore (. I used to (. when I was twenty-five, ((teethy inbreath\(^{15}\)))”). In terms of the medical import of this information, it seems at worst irrelevant and at best redundant. This invites analysis of what it may have been designed to accomplish beyond information provision. One thing this turn accomplished is further emphasizing the contrast between his current unproblematic alcohol use (“Na I don’t do it as much anymore<”) and his past problematic alcohol use (“when I was twenty-five, ((teethy inbreath)))”). What I have transcribed as a “teethy inbreath” is a relatively common vocalization used to elide something unmentionable or to create the effect that it is better left unsaid. It has a clearly negative evaluative dimension. Used in this context, the patient was indicating that his alcohol use when he was 25 was, in his view, markedly problematic. It should be noted that this patient was 33 years old at the time of the consultation, which provided for this conduct to be reasonably heard as ‘in his past.’ Given what he reported about his current alcohol use, he also provided for the interpretation that he has since resolved this problem. By framing his history of heavier drinking as a youthful indiscretion that has resolved itself, the patient restored his character.

\(^{15}\) It is difficult to adequately capture what I have termed a “teethy inbreath” using traditional conversation analytic transcription symbols. It is created by parting the lips while clenching the teeth together and drawing in a breath around the teeth. This creates a “whooshing” sound. I have heard speakers do something very similar to indicate pain, although my sense is that the inbreath is sharper and less drawn out in those instances.
For the next instance I return to Case 5, which I previously analyzed in terms of the patient’s delay and mitigation of agency in reporting on drug use. Here, I analyze the temporal formulations the patient employed to describe his drug use.

Case 5: F0928|4.09|”Not Writing”

1. Doc: Any drug use,
2. (.)
3. Pat: No.
5. (0.7)
6. Pat: .hh U::h let’s [see here.]
7. Doc: [Not writing] mh mh mh [mh]
8. Pat: [No] u:m
9. → prob’ly I- (t-) I think I took u::h (.) back in
10. → the early eighties it was uh occasional
11. marijuana,
12. Doc: Okay,
13. Pat: And u:h .hh (he) told me it was speed (.) but
14. that was prob’ly three er four times.
15. Pat: → N’that was prob’ly eighty: one (m)eighty
16. tw[o.]
17. Doc: [Or]al?

In lines 8-11, the patient indicated that he had used marijuana (“No u:m prob’ly I-(t-) I think I took u::h (.) back in the early eighties it was uh occasional marijuana,”).
Several observations can be made about the temporal formulation “back in the early eighties.”

First, the patient appeared to adjust his turn-in-progress in order to insert this piece of information. In line 9, he initiated his report with “I think I took ...h (.)” but prior to completing that syntactic unit, he provided this temporal formulation as a kind of parenthetical. As noted earlier, when speakers repair or adjust their utterances, they may be inspected for what the repair or adjustment was designed to address. In this case, the adjustment provided for his marijuana use to be heard by the physician as occurring in the distant past, some 20-25 years prior (this case was collected in 2006).

Second, this patient was 41 years old at the time of data collection, meaning that he was born around 1965. In the early eighties, this patient would have been in late high school or college. By locating his marijuana use at this time, the patient may have been working to have it understood as a ‘youthful indiscretion.’ It should be noted that the physician had access to the patient’s age in his medical record. Later in the consultation, the physician made mention of an “age 40 rundown,” a set of topics they should discuss given the patient’s age. Insofar as he was aware of the patient’s age, the physician was well equipped to make the youthful indiscretion inference from the patient’s reference to the early eighties.

Third, through two language choices in the formulation, the patient maximized the impression of how long ago he had used marijuana. First, the patient included “early” as a modifier of “eighties,” pushing his marijuana use to the most temporally distant part of the decade. Second, he used the preposition “back” (“back in the early eighties”), which emphasized the sense of temporal distance.
After reporting speed use in lines 13-14, the patient again volunteered temporal information, situating his use in 1981 or 1982, essentially the same period as the reported marijuana use. The physician did not seek information about the dates of drug use, nor did he visibly receipt or otherwise orient to the previous temporal information regarding marijuana use. I cannot know whether the patient thought that the specific dates of drug use were medically relevant, but based on these data, my sense is that physicians do not seek this information during routine medical histories. It is possible that they would seek it if it were to emerge as diagnostically relevant. In this case, it appears that the patient was working to have his speed use understood as something in his distant biographical past, not something that is relevant to his current identity or circumstances. By “splitting the self” in this way, the patient restored his character.

For the next instance I return to Case 3, which I previously analyzed in terms of the patient’s mitigating her own agency in problematic conduct. This instance is somewhat different from the others in this sub-section in that the patient, a 55-year old woman, was not working to cast her drinking as a ‘youthful indiscretion’ from her distant past. Rather, she framed it as a problem from her more recent past, but one that she had already resolved.

**Case 3: K0921|33.45]”Drinking After Work”**

1. **Pat:** So but I have I have been b- making a conscious
2. effort (.) tuh eat well.
3. ()
4. **Pat:** And um ,hh I: uh for a while I think I was
5. drinking too much an’ I just ((quickly shaking
6. → head no)) (.) s’rt of (.) do’n’t.
7. ((Physician looks up from laptop))
8. Pat: Y’know I might have couple beers an’
9. th[at’s all.]
10. Doc: [Drinking] alcohol too much,
11. Pat: [ Yea:h ] [but]
12. ((34 lines omitted))
13. Doc: [ So one- (. ) ] one beer a night?
14. (0.5) ((Patient sipping water))
15. Pat: Mm mm. (with water in mouth))
16. (1.0) ((Patient swallowing))
17. Pat: No: I had a- .h Not- I don’t drink every day I
18. been re- re- I was fer a while there and (say)
19. y’know what? (. ) this is way too much so I um .hh
20. na:h ab- abou- two er three.
21. Doc: ↑(N)kay.= ((nods))
22. Pat: =>Yeah.<

In lines 4-5, the patient reported that she had gone through a period of drinking too much alcohol (“A:nd um .hh I: uh for a whi:le I think I was drinking too much”), but worked to frame this as a resolved problem. In employing the phrase “for a whi:le…I was” the patient indicated that this had occurred over a finite period of time and that this period was over. She made this even more clear as she continued in lines 5-6 (“an’ I just ((quickly shaking head no)) (. ) s’rt of (. ) do:n’t.”) and in lines 8-9 (“Y’know I might have couple beers an’ that’s all.”). She reported a return to a more appropriate pattern of drinking, which further implied resolution of her period of problematic drinking.
Later in the sequence (lines 17-20), the patient invoked this period of drinking a second time and again worked to have it understood as resolved. I will briefly sketch the action between lines 12-17, as this contextualizes the patient’s second reference to her period of problematic drinking. In the sequence omitted in line 12, the physician and patient discussed the possibility that the patient’s recent weight gain may have been related to drinking too much beer. In line 13, the physician returned to history taking by querying the patient about the specific quantity/frequency of her current drinking. She formulated her query with a candidate answer (Pomerantz, 1988): “one beer a night?” In line 15, the patient (with water in her mouth) indicated that the candidate was not accurate (“Mm mm.”). In line 17, she displayed her interpretation of “one beer a night” as implying daily drinking, which she denied (“No: I had a- .h No-t- I d-o-n’t drink every day”). This could be seen as a somewhat defensive hearing of “one beer a night” and her strong vocal stress on “No-t” and “d-o-n’t” convey marked rejection of it. Through these features, the patient enacted the medically and socially approbated stance that drinking every day is a problematic activity.

Continuing in lines 17-18, the patient referenced her past problematic alcohol use for the second time (“I been re- re- I was fer a while there”). By stressing the word “was” in this location, the patient emphasized the contrast between her past and current conduct. As she had done in line 4, the patient employed the phrase “for a while” (“fer a while there”), again conveying that this had been a finite (i.e. resolved) period of problematic drinking. The patient’s use of “there” in this formulation conveyed an additional sense of retrospective detachment from this period.
In lines 18-19, the patient reported having an internal realization that she was drinking too much (“and (say) y’know what? (. . this is way too much so I um .hh”). She did not complete this utterance but the “so I um” projected a report of her response to the realization. Given what the patient had already indicated throughout this sequence, the physician could reasonably infer that her response was to cut back on her drinking. In line 20, the patient shifted tack to provide an answer to the physician’s alcohol quantity query from line 13 (“na:h ab- abou- two er three.”). By beginning her utterance with the negation token (“na:h”), the patient marked this “correction” as responsive to the physician’s candidate, “one beer a night?””. Although the patient ultimately did answer the physician’s query, thus displaying an orientation to the reporting demands of her situated patient identity, she preceded her answer with some materials that reasserted her trajectory away from problematic conduct and toward appropriate conduct. In so doing, the patient restored her character.

4. Employing Quantity or Frequency Formulations that Downplay the Magnitude of Problematic Conduct

Many aspects of lifestyle history taking are concerned not just with the presence or absence of conduct, but with the magnitude of conduct. This generally involves the quantity (“how much/many”) or frequency (“how often”) of particular behaviors. In many cases, the medical and/or moral status of some conduct as problematic or unproblematic depends upon its magnitude. A straightforward example is alcohol use; some quantities/frequencies are normal, even healthy, and others are problematic. The

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16 For example, because of the antioxidants, moderate wine consumption may be beneficial for heart health.
patients in these data appeared well aware that magnitude was relevant, often volunteering this information without prompting from the physician. When patients were reporting problematic conduct, they sometimes employed formulations that downplayed its magnitude, thus restoring character in the face of information that might invite inferences to the contrary.

For the first instance I return to Case 4, which I previously analyzed in terms of the patient’s use of the disclaimer that he knows he shouldn’t drink alcohol while on blood pressure medication. That sequence is omitted in line 5 below. As the sequence continued, the patient invoked the relevance of a recent trip to the Fingerlakes, a well-known wine region in New York State. In the ways that he presented the trip and the special stock of wine it made available to him, the patient was able to minimize the overall scope of his alcohol use. He also employed minimizing quantity/frequency formulations.

Case 4: R1004|9.56|"Pipe and Wine"

1. Doc: ((looking at laptop screen)) .h U::h(.) and then
2. in the past you told me (.) ((looking at
3. Patient)) only a glass er two of wine on occa-
4. on occasion=Is that still about the same?
5. ((12 lines omitted))
6. Pat:→ °I went on a w-° (0.5) a wine tour in the
7. → Fingerla[kes.]
8. Doc: [Yup,]
9. (0.3)
10.Pat:→ last month:
11.  
12. Pat:→ .hh and brought back some nice wines but (.)
13.  → that’s very rar[e w]here I [have wine.]
14. Doc:    [Yeah]  [An’ that’s fine] a
15. glass of wine .h occasionally’s not going to hurt
16. yo- even with the medicines that yer taking.=
17. Pat:→ =Probably an average of (2.0) twice a week
18.  → maybe?=    
20. Pat:→ At the [ most.]

In lines 17-18 and 20, the patient ultimately indicated an increase in his alcohol use since this last consultation with the physician (from 1-2 drinks on occasion to drinking twice a week). Before reporting this potentially problematic increase, the patient presented a range of details that served to minimize its magnitude.

By invoking his Fingerlakes trip and the “nice wines” (line 12) he procured there, the patient invited the inference that his increased consumption was a function of his having this special and limited supply of quality wine, not a change in his overall orientation to moderating his alcohol use. The patient surfaced this inference in line 13, when he reported that, “that’s very rare where I have wine,” employing vocal stress on the phrase “that’s very rare.” In claiming that it is rare for him to have wine, the patient implied that, once the special Fingerlakes wine supply runs out, he would naturally return to his normal levels of limited alcohol use. The patient downplayed the magnitude of his recent increased wine consumption by framing it as a temporary exception to the norm.
In lines 17-18, the patient provided a report of his current frequency of wine consumption (“Probably an average of (2.0) twice a week maybe?”)\(^\text{17}\). The “Probably” and “maybe” both served to frame this report with some measure of uncertainty, marking it as an approximation or best guess. In doing so, the patient framed his wine consumption as sufficiently irregular or inconsistent that he wouldn’t necessarily have the exact information at the ready. As Boyd and Heritage (2006) note, “too prompt a description of the quantity one drinks or smokes may be taken as indexing a preoccupation with smoking or drinking as something that one is concerned about” (p. 182). The patient’s approximations implied a casual detachment from any such preoccupations.

The patient also elected to frame this frequency as “an average of;” which did something more than just marking this as an approximation. In reporting an average, the patient conveyed that there are variations in his actual patterns of consumption from week to week. A straightforward hearing of this report is that there are weeks in which

\(^{17}\) It is worth noting that there were some 22 lines of interaction between the physician’s initial quantity/frequency query (lines 1-4) and this response. This interaction included the patient’s fairly elaborate disclaimer that he shouldn’t drink while on his medications and the contextualizing description of the Fingerlakes trip. This is a nice case in which to stress certain thematic points in the analysis. First, these activities strongly suggest that the patient was engaged in some project(s) beyond simple information provision. If that were the only project, one would not expect 22 lines of discourse between the question and the answer. Concerns about identity, specifically the restoration of character, provide an account for these ostensibly unnecessary activities. Second, in spite of these 22 lines of interceding discourse, the patient ultimately did provide an answer to the physician’s initial query. Although he engaged in some other activities first, he treated that query as still lively and relevant, eventually volunteering a numerical estimation without any obvious re-prompting by the physician. This can be understood in terms of an orientation to the situated patient identity and the expectation that they provide requested information. In giving an answer, the patient ultimately completed the sequence and allowed the history to progress.
his wine consumption is above the mean (i.e. problematic) and weeks in which it is below the mean (i.e. appropriate). While the patient had already framed his increased wine consumption as problematic in various ways, his use of an average formulation implied that he was not consistently drinking more than he should on a week-to-week basis, but rather that he had ‘good weeks’ and ‘bad weeks.’

In line 20, after the physician had receipted this report (“Okay.” in line 19), the patient added, “At the most” as an “increment” (Schegloff, 1996), an extension of an ostensibly complete utterance. Like repairs, increments can be examined in terms of the concerns that they are designed to address. Given that the physician’s “Okay.” had signaled closure on that sequence, the patient’s adding an increment displayed a measure of interactional initiative in getting these materials heard. This increment modified his prior report, claiming that the reported frequency (drinking wine twice a week) is better heard as an upper limit rather than an average, as he had just reported. This implied that his typical pattern of drinking is actually less than the upper limit of twice a week.

By invoking the Fingerlakes trip and by formulating his current wine consumption with minimizing features, the patient restored his character in an environment in which he was reporting a potentially character-threatening trend in his lifestyle conduct.

For the next instance I return to Case 1, which I previously analyzed in terms of the patient’s expressing regret about his number of lifetime sexual partners and his framing this as something from his past. Here, I examine the details of how the patient formulated his number of sexual partners.

Case 1: R10258.00”HIV Test Hard Sell"

1. Doc: How many lifetime sexual partners do you have.
Several features of the patient’s report in lines 6-7 worked together to subtly downplay the number of sexual partners he has had. As in Case 4 above, the patient formulated his report as an approximation or best guess. His turn-initial, “I’ll say” and his use of a range (“fifteen to twenty”) rather than a single number implied that this was an approximation. Whereas the patient in Case 4 used an average to do approximation, this patient used a range, and these methods have their differences. An equivalent average for this patient might have been something like, “About seventeen.” By using a range, the patient was able to voice the lowest (and least problematic) number in the range (“fifteen”), providing for the possibility that this could be the actual number. Thus, ranges specify how much interpretive ‘wiggle room’ is possible in an approximation and may invite interpretations at the contextually desirable pole of the range.

Prior to producing the range, the patient included the phrase “close to- close to:” This phrase can also project approximation and, given that it is produced twice and that the second instance is elongated, the patient may have been displaying an effort to remember. Many words and phrases could be used in this position to project numerical approximation: ‘about’; ‘around’; ‘roughly’; ‘maybe.’ It should not be assumed that these markers of approximation are interchangeable; different versions may be used to do different things. One way to think about markers of approximation is to consider the
implied direction of ‘measurement error.’ Some markers of approximation imply possible overestimation and others imply possible underestimation. These features invite inferences about where the actual number stands in relation to its reported approximation. In terms of the direction of measurement error, the phrase, ‘close to’ is functionally similar to another marker of approximation, ‘almost,’ which conveys that the actual number is somewhere below the approximated number. The phrase ‘close to’ is less explicit than ‘almost’ in this regard, but still does provide for the approximation to be heard as a possible overestimation, a threshold that wasn’t quite reached. In using “close to- close to:” the patient projected that the number (or range) that he was about to produce was possibly an overestimation. In doing so, the patient downplayed the magnitude of his problematic conduct. Although he went on to express regret about his history, his initial formulation worked in various ways to invite character-restoring inferences about just how many sexual partners he has had.

For the next instance I return to Case 5, which I have used to illustrate many other practices in this chapter. Here, I examine the patient’s use of the frequency descriptor “occasional” in reference to drug use.

Case 5: F0928|4.09|”Not Writing”

1. Doc: Any drug use,
2. (.)
3. Pat: No.

By contrast, an example of a marker of approximation that projects possible underestimation is ‘at least.’ A fisherman who reports that he caught ‘at least 10 fish’ is inviting the inference that it actually may have been more than 10.
In lines 9-11, the patient reported past use of marijuana. The patient provided an indication of the magnitude of his use by including the term “occasional.” This implied that his marijuana use was not patterned or recurrent, which might suggest habitual use or even dependence. ‘Occasional’ can also convey that his marijuana use was limited to circumstances in which marijuana use is more normatively permissible (e.g. concerts, parties, etc.). The patient restored his character by minimizing his past use of an illegal and comparatively deviant substance.

Section Two: Physicians’ (Limited) Involvement in Restoring Patient Character

As I have noted, Goffman’s dramaturgical metaphor conceptualizes identity enactment as a collaborative venture between social actors. This leads me to consider the ways in which the physician (the other actor in the scene) may have been involved in the restoration of patient character. As with analytic chapter one, physicians appeared to be relatively uninvolved in this. They generally maintained an emphasis on the on-record activity framework of history taking and their role as information seekers. They did not appear to support, undermine, or even register the characterological implications of patients’ talk. In the conclusions chapter, I consider some explanations for this general pattern. That said, the physicians in these cases did engage in one interactional practice
that could be seen as restorative of character. That practice involved the use of normalizing candidate answers.

Offering a Normalizing Candidate Answer

This analysis relies on research by Pomerantz (1988) on the phenomenon of “candidate answers.” I describe this phenomenon briefly in the literature review chapter and provide a more detailed overview here. When a speaker formulates an information seeking action (typically a query) her or she may package it with a candidate answer. A candidate answer supplies the recipient with a possible answer to the query, often reflecting the information seeker’s best guess about the matters in question. An example of an information seeking action that does not include a candidate answer is, “Where are you going?” An example of an information seeking action that does include a candidate answer is, “Are you going to the store?” In the second version, the speaker incorporates a possible answer (i.e. going to the store) into the query itself. One advantage of seeking information with a candidate answer is that the candidate can serve as a model for what would satisfy the information seeker’s purpose in seeking the information.

Although candidate answers are employed primarily to seek information, Pomerantz argues that they can also accomplish a range of other social and interactional functions. Two such functions are particularly relevant for this analysis. First, in supplying a candidate answer, an information seeker can display knowledge of, or familiarity with, the matters in question. Second, candidate answers can be heard as revealing the information seeker’s expectations of the relevant persons or situations in question. These expectations can also communicate an evaluative stance toward those persons or situations. The second feature relies upon the first; it is the claimed familiarity...
with the matters in question that provides for the intelligibility of displaying an expectation regarding those matters. Pomerantz notes that the speakers she analyzed tended to employ a “legitimate action” (p. 372) as a candidate answer, displaying the expectation that the recipient’s conduct or circumstances have been normatively appropriate. For example, if I don’t answer the phone when she calls me, my wife might ask me later that night, “Were you working on your dissertation when I called you this afternoon?” In contrast to a version like, “Why didn’t you answer when I called?,” the candidate answer version displays the legitimizing expectation that I had a good reason not to answer the phone. This feature suggests that information seekers orient to candidate answers as potentially identity implicative and work to avoid the appearance that they are making unflattering inferences or attributions about the recipient.

In these data, physicians appeared to employ candidate answers in just this way, displaying the expectation or inference that patients’ lifestyle conduct had been normatively appropriate. This is what I refer to as a “normalizing candidate answer.” In offering normalizing candidate answers, physicians collaborated in enhancing the patient’s character.

I have argued throughout this analysis that patients generally engaged in identity management in a subtle, off-record manner, displaying an on-record orientation to their situated role-based obligation/entitlement to report information and advance the history. Physicians’ use of normalizing candidate answers can be understood in much the same way. Seeking information is a thoroughly role-appropriate activity for physicians during history taking. Offering a normalizing candidate answer allows the physician to seek
information and advance the history while also working to tacitly preserve a view of the patient as normatively appropriate.

In this instance, the physician queried the patient about the quality of his marital sex life. He employed a variety of candidate answers throughout this sequence.

Case 8: F0928|13.48|”Problems with Erections”

2. Pat: °No.°
3. Doc:°No,° Happy with your sex life:, Happy with
4. °your:,°
5. Pat: Could be more but [(y’know)  haha]
6. Doc: [Could be more.] Right.
7. (0.2)
8. Doc: Okay
9. (0.2)
10. Doc:°h U::m you say could be more: just (. ) ((sniff))
11. °(. ) [ti::me,]
12. Pat: [(   )] Yeah.=
13. Doc:°=Jus’ (. ) because there’s not enough time:,°
14. °[ there’s not a, ]
15. Pat: °[Well wit’ two kids]=
16. Doc:°=With two kids there’s not enough privacy
17. °(. ) ((Patient nods))
19. (0.5)
In line 1, the physician queried the patient about his erectile function and the patient indicated that he was having no problems. In line 3, the physician receipted this report and then sought information about the quality of his marital sex life (“Happy with your sex life::, Happy with your:;”). The design of the second query was potentially responsive to the patient’s report of no erectile problems. Rather than asking, “How is your sex life?,” which would display no particular expectations about his sex life, the physician incorporated the candidate answer, “Happy with your sex life::,” where the candidate is that he is “happy” with it. While this query did give the patient an opportunity to report any sexual problems, the physician’s format displayed an expectation that there weren’t any. He supplied the normatively desirable candidate answer that the patient’s marital sex life was satisfying. Given its sequential position, the physician could be heard as making the inference that the absence of erectile problems meant that the patient was likely to be satisfied with his sex life. This is an alternative to a more neutrally framed query. It is also possible that the design of the query was pro forma, a standardized way for this physician to display an optimistic expectation about his patient’s lifestyle circumstances (see Boyd & Heritage, 2006 on physicians’ ‘no problem’ query formats). In either case, the candidate answer “Happy with your sex life::,” served as a resource for framing the patient’s marital sex life in a normatively desirable way.

In line 5, the patient responded with a mild complaint about the frequency of sexual activity and then laughed (“Could be more but (y’know) haha”). Dissatisfaction with one’s marital sex life could be understood as normatively problematic or undesirable. Although the patient mitigated the force of the complaint by laughing, the
physician treated the patient as having raised a genuine issue. He displayed understanding and alignment in line 6, repeating “Could be more.” and confirming with “Right.” In line 8, he provided a closing implicative receipt token (“Okay”) but in lines 10-11 he provided a follow up query about the patient’s complaint (“h U::m you say could be more: just (.)(sniff)(.) ti::me,). The physician was seeking an explanation for the infrequency of sexual activity, likely because some bases for infrequent sexual activity may be medically relevant and/or treatable. In again invoking the patient’s prior complaint (“you say could be more:”), the physician positioned this as the basis for additional discussion. He also treated this complainable circumstance as accountable, warranting further explanation.

The physician’s query offered the candidate answer “ti::me,” as a possible explanation or account, meaning that he and his wife lacked time for sexual activity (the physician made this more clear in lines 13-14). The physician marked this as a candidate answer intonationally, emphasizing its ‘placeholder’ status by elongating the word and using continuing intonation. Note that the physician might have queried the patient by asking, “What are some reasons you’re not as active as you’d like to be?” Instead, he supplied the candidate answer that they lacked the time, putting this forward as a possible account for their infrequent sexual activity. Among the many possible reasons for infrequent sexual activity (including a wide range of possibly character-implicative psychological, emotional, or relational problems), lack of time is relatively commonplace and both normatively and medically benign. The physician already knew that the patient was married with two children, so in invoking “tim::e,” the physician may have been trading on shared cultural understandings about the demands of family life. In offering up
this normalizing account for infrequent sexual activity, the physician was able to seek additional information about a possible medical complaint while also displaying the expectation that the patient’s marital sex life was hampered by a relatively benign cause.

In line 12, the patient spoke in overlap with the physician’s “ti::me” but showed that he still heard it by providing confirmation (“Yeah.=”). Perhaps because of the overlap on the word “ti::me,” the physician provided a second version of this candidate account that more clearly framed it as an account (“=Jus’ .) because there’s not enough time:, there’s not a,” in lines 13-14). The patient responded with, “Well wit’ two kids=.” The patient tacitly invoked shared cultural understandings about the demands of raising children to provide a more specific account for the lack of time. This functioned to confirm the physician’s candidate account but also supplied more detail about its basis. In line 16, the physician provided an alternative interpretation of this detail (“=With two kids there’s not enough pr’vacy”). This could be thought of as a “candidate interpretation,” in that the physician was checking out if his interpretation of the patient’s report is accurate (i.e. that lack of privacy is another reason). In line 17, the patient nodded, confirming this interpretation. Like lack of time, lack of privacy from children is a fairly commonplace and normatively unproblematic basis for less frequent sexual activity within a marriage. By offering up this candidate interpretation, the physician surfaced an additional normalizing explanation (lack of privacy) on behalf of the patient.

In this sequence, the physician and patient co-constructed a portrayal of the patient’s marital sex life, developing a face-saving account of a complainable circumstance. While fulfilling his role-based obligation to seek information and address possible problems, the physician had a hand in offering up two different normatively
appropriate explanations for infrequent marital sex. The patient confirmed these candidate explanations when they were offered.

While I would argue that there was something identity enhancing about the physician’s use of normalizing candidate answers, I would also grant that it is not obvious how the patient’s character (as I have defined it up to this point) was at stake here. Certainly I see no evidence that the patient’s health consciousness was a concern, nor were his courage, integrity, self-discipline, etc. However, one “worst possible reading” of the patient’s complaint is that his wife is sexually disinterested in him or is unwilling to satisfy his desires. While I cannot cleanly associate this with the patient’s character, I would argue that it represents an undesirable portrayal of one’s lifestyle circumstances. In that sense, one can examine the physician’s queries in terms of how they provided a more desirable portrayal. Despite the ‘looseness’ of the character concept here, I include this case in order to explore some ways in which physicians might collaborate in constructing patients’ circumstances as unproblematic.

For the next instance, I return to Case 3, which involves the patient who recognized she had been drinking too much and reduced her drinking back to unproblematic levels.

Case 3: K0921|33.45|”Drinking After Work”

1. Pat:  A:nd um .hh I: uh for a whi:le I think I was
2. drinking too much an’ I just ((quickly shaking
3. head no)) (. ) s’rt of (. ) do:n’t.
4. ((Physician looks up from laptop))
5. Pat:  Y’know I might have couple beers an’
6. th[at’s all.]
In lines 5-6, the patient provided an estimate of her reduced pattern of drinking ("couple beers an’ that’s all."). The physician had been attending to the patient’s electronic medical record (EMR) on her laptop, but looked up after the patient reported
this. In line 7, the physician sought clarification that the patient meant she had been drinking alcohol too much, which the patient confirmed in line 8. Although the patient had framed this as a resolved problem, in bringing it to the physician’s attention, she also treated it as worthy of some attention. In lines 11-12, the physician initiated some history taking about the patient’s drinking, querying her about the type of alcohol she had been drinking. In doing so, the physician tacitly confirmed that this was worthy of some further discussion. In the sequence omitted in line 14, the physician and patient discuss the possibility that the patient’s drinking beer may have been responsible for a recent weight gain. In line 15-16, the patient provided the last turn in this sequence, pointing out the irony that red wine and chocolate are now considered health foods in some circles.

In line 17, in partial overlap with the patient’s prior turn, the physician returned to history taking, providing another query about the patient’s alcohol use (“So one- (.) one beer a night?”). The turn-initial “So” accomplished various things. It was transition implicative, proposing closure on the previous discussion and implying resumption of a previous activity. “So” can also project an ‘upshot,’ a speaker’s version or interpretation of a previous action. Speakers can use an upshot to show how they are understanding the ongoing flow of actions and information in interaction. Here, the physician’s “So” marked “one beer a night” as an attempted interpretation of the patient’s current pattern of reduced drinking. Rather than asking, “How much/often do you drink now?,” the physician incorporated a candidate quantity/frequency of drinking for the patient to confirm or disconfirm.

It isn’t entirely clear from the interaction where this candidate might have come from. In lines 5-6, the patient had reported that she now has “couple beers an’ that’s all.”
This is a larger quantity than the physician’s “one beer,” and the patient did not report on the frequency with which she consumes this quantity. The physician’s candidate is thus poorly fitted to what the patient had already reported. As noted, the physician had been attending to the patient’s EMR during her initial report and may not have been fully listening at that point. They had also engaged in a somewhat complex and playful discussion of beer and weight gain, so the physician may have forgotten the patient’s earlier report of “couple beers an’ that’s all.” In any event, the candidate pattern of drinking that the physician offered was supportive of the patient’s character-restoring claims of having corrected herself. It displayed the expectation that the patient had indeed succeeded in reducing her drinking back to appropriate levels.

Nonetheless, the patient did not confirm the physician’s normalizing candidate. In line 19, she disconfirmed it (“Mm mm”) and in lines 21-24, she clarified her pattern of drinking (“No: I had a- .h Not- I don’t drink every day I been re- re- I was fer a while there and (say) y’know what? (.) this is way too much so I um .hh na:h ab- abou- two er three.”). In the first part of her utterance, the patient denied that she drinks every day, casting that as something she had been doing when she was drinking too much. As previously noted, this appears to be a rather defensive hearing of the physician’s candidate. Whereas the physician had used the frequency metric “one beer a night” (meaning ‘per night’) the patient transformed that into “every day” in her rejection of the candidate. This is similar in spirit to a phenomenon that Boyd and Heritage (2006) refer to as a “righteous rejection,” a strenuous rejection through which a speaker enacts a moralistic stance toward the matters in question. By casting the physician’s query as implying daily drinking, the patient was able to not just deny this, but also denounce it as
‘outrageous,’ inapposite to her own drinking sensibilities. In the last part of her utterance, the patient reported a quantity of ‘about two or three,’ ultimately indicating that she drinks less often, but in greater quantities than the physician’s candidate had proposed.

Although the patient disconfirmed the physician’s normalizing candidate, she used it as ‘raw materials’ with which to construct a contrastive image of herself as moderate and responsible. This case thus provides a view of co-constructed identity that does not imply a coordinated, strategic partnership between interlocutors. In some cases, co-construction of identity can be understood in terms of interlocutors’ jointly producing meaning-making resources that either participant can transform, exploit, extend, etc. for the purposes of identity management.

The next case is a little different from the first two. In this case, the physician employed a normalizing candidate, but in the context of a somewhat different type of information seeking action. After the patient reported drinking heavily when he was younger (he was 33 at the time of the consultation), the physician offered a normalizing candidate account that this took place while the patient was in college. This functioned as an information seeking action in that it was designed for confirmation or disconfirmation and, in fact, received confirmation from the patient. However, it was less about eliciting new information than it was about securing the proper context for understanding already reported information. I previously analyzed this case in terms of the patient’s casting his heavier drinking as ‘in the past.’ Here, I emphasize the physician’s proffering a sympathetic, normalizing candidate context for such drinking.

Case 7: R1025|7.22|"College Drinking"

2. (1.2)
((Physician looks up from EMR to Patient))

4. Pat: Not as much as I used to.


6. Pat: [So:] I mean, (1.5) one er two beers a week.


8. Pat: =If that.

9. (0.4)

10. Pat: En (.) when I go out maybe once a week I’ll have

11. maybe more than that but (0.4) .hh that’s maybe

12. like twice ( ) [[at home]]

13. Doc: [ “M hm” ]

14. Pat: >Na I don’t do it as much anymore< (.) I used to

15. (. ) when I was twenty-five, [([teethy inbreath)])

16. Doc: \[
\text{Yeah (0.2) when yer}
\]

17. \[
\text{in college.}
\]

18. Pat: =Yeah: [ h ]

19. Doc: [“Yeah”] (. ) where dja go ta school,


21. (1.0)

22. Doc: Known fer: uh:,

23. Pat: Big parties [(there)]

24. Doc: [ Yeah ] having some (0.2)

25. festivities there.

In line 4, the patient implied some history of heavier drinking and in lines 14-15, the patient volunteered specific details about when this occurred (“>Na I don’t do it as much anymore< (. ) I used to (. ) when I was twenty-five, ((teethy inbreath)))”). I previously argued that the patient portrayed his drinking at age 25 as a ‘youthful indiscretion’ he had since outgrown.

The physician first provided an affiliative receipt token (“Yeah”), displaying not just understanding, but acknowledgment or affirmation. He may have been displaying familiarity with these kinds of ‘in my past’ moves. He then invoked college as another period at which people may drink more heavily (“when yer in college.”). In loosely recycling the patient’s format (“when” + (subject) + (circumstance)), the physician formulated this as an alternative completion of the patient’s utterance, another instance of youthful indiscretion. This reference traded on shared cultural knowledge about the relative normative latitude associated with college drinking, a once-in-a-lifetime opportunity to let loose in relatively secure environment. In employing the generalized “you” (“when yer in college”), the physician framed this as a typical experience for college students, thus further normalizing the associated drinking. The physician displayed a sympathetic attitude toward the idea of youthful drinking by supplying another context in which it may be appropriate. In line 18, the patient confirmed the applicability of the physician’s candidate (“Yeah:”) and in lines 19-26, the physician and patient further discussed the patient’s college drinking experiences. In collaboratively constructing the patient’s specific college as a known party school, they further normalized those experiences. In working to normalize potentially problematic lifestyle behavior, the physician collaborated in restoring the patient’s character.
Summary

As in analytic chapter one, in this chapter I argued that patients’ responses to routine lifestyle queries departed in some ways from the typical responses observed in comprehensive medical history taking. Rather than providing only minimal, fitted, information-oriented reports, patients engaged in some more elaborate reporting activities. Whereas patients in analytic chapter one enacted ‘no problem’ stances toward their conduct, patients in this chapter enacted ‘possible problem’ stances, at least in their initial responses to physicians’ queries. In enacting ‘possible problem’ stances, patients provided the raw materials for character-threatening inferences. In this chapter, I described and illustrated four practices that served to restore character in environments in which it may be in question. In various ways, these practices served to pre-empt “worst possible readings” of patients’ conduct.

While my emphasis was on the restoration of character, I also argued that patients displayed an overarching concern with appropriately fulfilling the obligations of their situated identity as patients. As in analytic chapter one, this meant working to restore character in ways that did not unduly disrupt the orderly progression of the history. Restoration of character never appeared to be the primary interactional business; it was largely embedded into ostensibly routine history taking activities.

As in analytic chapter one, I argued that physicians were largely uninvolved in restoring patient character. However, I did describe and illustrate one interactional practice for seeking information (employing normalizing candidate answers) that could be seen as subtly supportive of patient character. Like patients, physicians maintained an on-record orientation to the obligations of the physician role. Seeking information is an utterly role-appropriate activity for physicians during routine history taking; employing
normalizing candidate answers represents a way to subtly support patient character without abandoning their information seeking agenda.
CONCLUSIONS

Overview

In this chapter, I present my primary conclusions and consider some additional questions that were prompted by them. I then discuss the implications of my findings for the two literatures I reviewed: health communication and language and social interaction. Finally, I discuss some limitations of the analysis and suggest directions for future research.

Conclusions

In this section, I address my research question, summarizing the main findings of this analysis, and then address three additional questions that were prompted by these findings.

Main Findings

RQ1: In what way(s) is ‘lifestyle’ history taking shaped by concerns about identity?

My primary findings are centered on the identity implications of patients’ activities during routine lifestyle history taking. In my data, I found evidence of two different identity management ‘projects’ among patients. Both projects involved balancing concerns about two aspects of identity: situated identity and character. Both projects also involved the use of subtle and indirect practices of identity management. These practices relied upon physicians to recognize the shared cultural knowledge that patients were tacitly invoking in their responses.

One project was the enactment of strong character, described in analytic chapter one. I argue that some patients responded to routine lifestyle queries by enacting evaluative, ‘no problem’ stances toward their reported conduct or circumstances. This
represents an alternative to patients’ simply providing information in the minimal, closed-ended formats typical of routine history taking. In enacting these stances, patients tacitly made the case that their conduct should be understood as normal, unproblematic, or even desirable. I argue that this work can be accounted for in terms of patients’ efforts to enact strong character, showing themselves to be morally, normatively, and/or medically appropriate persons. In the ways that they enacted strong character, patients also displayed an orientation to their situated role identity as patients and the expectation that they fulfill the interactional obligations of that role. In practice, this meant that patients wove character-enhancing features into responses that ostensibly fulfilled the informational demands of physicians’ queries. Thus, the enactment of strong character appeared to be an off-record accomplishment embedded within the on-record activity context of history taking. In analytic chapter one, I discussed three interactional practices that patients used to enact strong character: (1) Employing a syntactically, intonationally, or interactionally marked ‘no-type’ response; (2) volunteering normalizing details about the type, quantity, frequency, or circumstances of conduct; (3) Evaluating conduct as normal or unproblematic. In these data, this project was only undertaken during substance use histories. I consider some possible explanations for this outcome in a subsequent section.

The second project was the restoration of character, described in analytic chapter two. I argue that some patients responded to routine lifestyle queries by enacting evaluative, ‘possible problem’ stances toward their conduct or circumstances. In contrast to those patients who enacted strong character, these patients explicitly or implicitly framed their conduct as potentially problematic. In framing their conduct in this way,
patients furnished the ‘raw materials’ for character-threatening inferences. Threats to character provide for the relevance of restoring character, working to resist the “worst possible readings” (Goffman, 1971, p. 108) that might be drawn from their information. This can be understood as a form of remediation. Like the enactment of strong character, the restoration of character was accomplished in ways that exhibited sensitivity to the situated patient identity and its associated obligations. Patients maintained an on-record orientation to their role as reporters of accurate and useful information, but fulfilled that role in ways that also implicitly enhanced their character. In analytic chapter two, I discussed four interactional practices that patients used to restore character: (1) Displaying independent awareness that reported lifestyle conduct is problematic; (2) Mitigating personal agency in problematic lifestyle conduct; (3) Framing problematic conduct as ‘in my past’ or already resolved; (4) Employing quantity or frequency formulations that downplay the magnitude of problematic conduct.

While I primarily address patients’ activities in this analysis, I also discuss some ways in which physicians were involved in patients’ identity projects. The rationale for examining physicians’ conduct emerged out of Goffman’s claim that social interaction, including identity enactment, is best understood as a collaborative venture between social actors. That said, the physicians in these data did not seem particularly involved in patients’ identity projects. This doesn’t necessarily mean that they didn’t notice the kinds of ‘special’ interactional work in which patients were engaged or that they didn’t make some inferences about what their patients were up to. On the contrary, I expect that their medical training and daily experiences with patients had equipped them well to recognize the kinds of impression management that patients might undertake in these domains.
Though physicians may have apprehended this work, they did not appear to orient to it interactionally. Perhaps even more so than patients, physicians maintained an emphasis on the history taking activity and their situated role-based obligation to seek information and efficiently progress through the history. While my general impression is that physicians remained uninvolved in patients’ identity projects, I do describe a few practices that could be seen as supportive of them. I regard these claims as tentative, but worthy of further investigation. In analytic chapter one, I discussed: (1) physicians’ almost never following up when a patient initially framed his/her conduct as normal or unproblematic and (2) physicians’ providing hearings that helped to surface the evaluative case the patient was making. In analytic chapter two, I discussed physicians’ offering normalizing candidate answers.

**Three Additional Questions Prompted By These Findings**

In this section, I consider three additional questions that pertain to the main findings of the analysis. These questions help to further account for some of the patterns observed in these data: (1) What comparisons can be made between patients’ practices for enacting strong character and for restoring character?; (2) Why were there no instances of patients’ enacting strong character during sexual history taking?; (3) Why were physicians relatively uninvolved in patients’ character projects?

1. **What Comparisons Can Be Made Between Patients’ Practices for (1) Enacting Strong Character and (2) Restoring Character?**

   The two identity management projects I describe in this analysis share some overlapping features, three of which will be highlighted here. First, both projects involved patients’ evaluating their information rather than just reporting it. Patients
worked to exert some influence over what might be made of their conduct. Second, both projects made use of indirect or implicit interactional practices; neither project was accomplished with explicitly character-implicative talk. These implicit interactional practices relied upon physicians to recognize the shared cultural knowledge that patients were invoking in their responses. Third, both projects involved practices that minimized or contextualized conduct. Patients displayed their understanding that the perceived problematicity of lifestyle conduct depends largely on its scope or magnitude and employed practices that appeared designed to position themselves within an acceptable part of the curve. It should not be surprising that these projects shared some basic similarities, as they both involve an effort to project a socially and/or medically desirable identity.

In my view, the most important differences between the practices involved in each project can be captured in terms of Goffman’s (1971) notion of “splitting the self” (p. 113). This refers a broad class of remedial activities in which the speaker constructs a blameworthy version of self and a conscientious version of self, one who can stand back and acknowledge what has been blameworthy. This sort of work is made relevant only when there is something blameworthy on the table, which, by definition, was not the case when patients were enacting strong character. It was only when their information had the potential to threaten character that splitting the self became a relevant move for patients. The practices of framing conduct as potentially problematic, mitigating personal agency in problematic conduct, and framing problematic conduct as ‘in my past’ all obviously depend on there being some problematic conduct to be positioned in these ways. Each of these practices involves splitting the self into a part that committed an ‘offense’ and a
part that can independently recognize and remediate for it. Although both projects ultimately involve the projection of a desirable identity, the restoration of character arguably requires more complex and ambivalent interactional strategies that admit fault while still saving face.

2. Why Were There No Instances of Patients’ Enacting Strong Character During Sexual History Taking?

In analytic chapter one, I noted that every case of patients’ enacting strong character came from the substance use subset of my data; there were no cases from the sexual history subset. This outcome could be explained in a few different ways.

One possibility is that this was simply an artifact of my data. There were more consultations that included substance use discussions (17) than sexual activity discussions (12) and more instances of the latter might have revealed efforts to enact strong character. In addition, some of the 12 sexual discussions did not have the standardized shape of a sexual history, which would generally include a series of queries such as: Are you sexually active?; How many sexual partners have you had?; Do you use any form of STI/pregnancy protection?; Have you ever had an STI?, etc. These are the sorts of queries that might have provided structural opportunities for the enactment of strong character.

By contrast, in one of the 12 cases coded as a sexual discussion in this corpus, a physician replied to a patient’s question about scheduling a pap smear by jokingly remarking that she only needs one if she has a new boyfriend. The physician knew that this middle-aged patient was married and the patient seemed to get the humor. She jokingly ‘reminded’ the physician that she has a husband. While I included this case in my count because it touched on issues related to sexual partnerships and infidelity, there
were no clear structural opportunities for the patient to report health information in terms of character. Several cases of sexual discussions in this corpus have this somewhat loose, informal shape and this may partly explain why I could find no instances of patients’ enacting strong character in this domain.

Of course I can only speculate, but I would expect that patients sometimes do enact strong character during sexual histories. For example, if a physician were to ask a 14-year-old female if she had been sexually active, she might respond with a marked ‘no-type’ response (e.g. “Oh no way!”). If a physician were to ask an adult patient how many sexual partners s/he has had, s/he may respond with evaluative approximations (e.g. “Not too many at all. I’d say a handful at the most”). More data would be needed to determine whether or not these sorts of things actually occur during sexual histories.

Another possible explanation is that the domains of substance use and sexuality are simply different in terms of the clarity of the socio-cultural standards that might be used to judge conduct as ‘good’ or ‘bad.’ There appeared to be widespread understanding among these patients about what would count as an unassailable substance use profile: no smoking; moderate use of alcohol (preferably beer; preferably consumed socially; preferably on weekends); no drug use. Sexuality is arguably more complex, more varied, and more taboo than substance use, and there may be less widespread agreement about what would project normality or desirability in this domain. For this reason, patients may maintain a minimalist, information-centric approach to answering sexual history queries unless and until they have something problematic to report and, as shown in analytic chapter two, they do have resources for restoring character in such cases.
Ultimately, the fact that one of the two major identity management projects I described (the enactment of strong character) relied on data from only one topical domain raises questions about the wisdom of collapsing substance use and sexual activity under the rubric of ‘lifestyle.’ Perhaps these domains are better understood by looking at them separately and working to appreciate the distinctive cultural meanings that are bound up in them.

3. Why Were Physicians Relatively Uninvolved in Patients’ Character Projects?

I offer three possible explanations for physicians’ limited involvement in patients’ character projects during routine history taking. First, patients’ practices of identity management were generally accomplished in a tacit, off-record manner. As Bonito and Sanders (2002) argue, speakers sometimes design their talk to produce an effect without demanding that its recipient overtly acknowledge that effect. Were physicians to more overtly support patients’ identity projects, it could risk exposing work that the patient had designed to function in a more covert way. Given my reading of Goffman as suggesting that impression management is best done ‘between-the-lines,’ physicians’ “tactful inattention” (Goffman, 1959, p. 230) to the identity implications of patients’ performances may actually be more supportive than open acknowledgement.

Second, if physicians were to openly support patients’ character projects, they risk tacitly confirming that these kinds of identity inferences and evaluations are relevant to the medical business at hand. Physician training references advise physicians to create a ‘non-judgmental tone’ in matters of lifestyle (e.g. Andrews, 2000; Wincze & Carey, 1991) and even character-enhancing efforts by the physician could invoke the relevance of moral judgment. By maintaining a focus on history taking, physicians asserted the
relevance of information exchange and resisted the relevance of character evaluation. Put another way, physicians may have been working to ‘medicalize’ rather than moralize these topics.

Third, physicians may have been orienting to time constraints. Routine medical histories are quite time consuming and physicians may have felt that their time was better spent seeking the next bit of information than assuring patients that their identities were unspoiled.

Implications

In this section, I discuss some implications of these findings for the two broad literatures I addressed in the literature review: (1) health communication research and (2) research on language and social interaction.

(1) Health Communication Research

Reconceptualizing Patients as Active Agents in Medical Consultations

Past research on physician-patient interaction has tended to emphasize the asymmetries that exist between physicians and patients, where physicians generally are conceptualized as dominating the interaction. Much of this dominance has been attributed to the institutionalized nature of the medical encounter and the ways in which its component activities provide participants with an asymmetrical distribution of role-based entitlements and constraints. During history taking, physicians have a role-based entitlement/obligation to seek information and patients have a reciprocal role-based entitlement/obligation to report information. Physicians also have a role-based entitlement/obligation to evaluate patients’ information in terms of its medical implications. Researchers have argued that these expectations, and the interactional
structures through which they are realized, tend to subordinate patients’ perspectives during medical encounters. This may be particularly pronounced in the relatively restrictive environment of routine history taking, which is generally organized around series of closed-ended queries from the physician and minimal, type-conforming responses from the patient. In this tightly structured, information-intensive environment, we might expect that patient agency is limited to simply answering the physician’s questions.

However, this analysis suggests that patients are engaged in much more than answering questions during routine lifestyle history taking. I argue that patients were engaged in identity management projects, which is to say that they were working to implement their own agenda, not just satisfy the institutional requirements of the occasion. This agenda essentially involved shaping the sense that might be made of their lifestyle conduct, rather than leaving that fully up to the physician. This could be seen as a rhetorical agenda as much as an informational one. Patients treated themselves as capable of evaluating the medical implications of their conduct, both positive and negative. Moreover, they treated themselves as entitled to bring these evaluations to bear on the interaction. In some cases, patients portrayed themselves as independently monitoring and addressing possible problems on their own.

This degree of patient agency may be unique to lifestyle matters. Some researchers (Johanson, Satterlund Larsson, Saljo & Svalsudd, 1998; Sorjonen, Raevaara, Haakana, Tammi & Perakyla, 2006) have argued that lifestyle health occupies a middle ground between the scientific, biomedical perspective into which physicians are professionally acculturated and what Mishler (1984) has termed the patient’s “lifeworld”
perspective. This essentially refers to the subjective, cultural, and experiential dimensions of health and illness. As cultural co-members, physicians and patients can expect one another to have mutual access to prevailing cultural ideas about lifestyle behavior. Whereas patients may defer to physicians’ evaluative expertise when it comes to technical, physiological aspects of health, patients may appeal to the applicability of their shared “lifeworld” knowledge in matters of lifestyle. They may feel they are reasonably equipped and entitled to draw on these everyday cultural understandings and to position their own conduct with respect to these understandings.

The findings of this study complement an established body of literature on patient agency in the medical encounter. Recent research on patients’ diagnostic work (Gill, 1998; Gill & Maynard, 2006; Gill, Pomerantz & Denvir, forthcoming; Pomerantz, Gill & Denvir, 2007) and their pursuit and resistance of treatments (Ainsworth-Vaughn, 1995; Costello & Roberts, 2001; Gill, 2005; Stivers, 2002) has painted a more nuanced picture of the physician-patient relationship and the asymmetries that were long thought to effectively silence patients during the encounter. While it has been, and continues to be, instructive and appropriate to expose the structures of physician dominance, this emphasis has arguably led to an under-appreciation of the interactional resourcefulness with which patients express their own perspectives and shape the medical encounter.

Accounting For Physicians’ Not Conducting More Thorough Lifestyle Histories

In the introductory chapter, I presented some literature that showed that lifestyle history taking tends to be difficult for physicians and patients and, as a result, is often superficial (Friedmann, McCullough, Chin & Satz, 2000; Maheux, Haley, Rivard & Gervais, 1995; Schauffler, Rodriguez, & Milstein, 1996). There is widespread concern
that this leads to underreporting of otherwise treatable health problems. Numerous researchers and medical educators have called for research that explores the complexities and challenges of history taking in these domains.

In my view, these concerns were exemplified in my data, particularly in analytic chapter one (The Enactment of Strong Character). In those cases, physicians generally conducted much less thorough substance use histories than the medical training literature would recommend. For example, they were very inconsistent in inquiring about past drug use and never inquired about periods of heavier episodic drinking (i.e. binge drinking) within patients’ normal patterns of limited drinking. When patients provided evaluative glosses, physicians did not pursue specific numbers that would allow them to make their own professional judgment. This was less true of physicians in the second analytic chapter (The Restoration of Character). When patients initially framed their conduct as potentially problematic, physicians did follow up with more thorough history taking. This may have been because the patient’s acknowledgement of a problem provided a visible warrant for further exploration. But when patients framed their conduct as normal or appropriate, this effectively precluded further information seeking from physicians, even if significant information had not been elicited. How can we account for this?

Previous interview-based research has explored some cognitive/attitudinal barriers. Physicians may feel that they do not have time, energy, or cause to pursue the possibility of substance use issues with patients who are presenting themselves as normal or appropriate (Rapley, May & Kaner, 2006; Thom & Tellez, 1986). This work has shown that physicians become frustrated and discouraged by the prospect of working to unearth substance problems that patients are unwilling to discuss on their own. They also
point to a lack of institutional incentivization for addressing substance use with patients, which may curtail motivation to pursue potentially rapport-threatening lines of inquiry. In short, when patients are presenting themselves as problem-free, physicians may feel that they are best served by simply accepting the patient’s viewpoint.

Based on my analysis I would offer another account, one that is compatible in many ways with these perspectives. However, my account is interactional rather than attitudinal. When patients frame their alcohol use as normal or imply that drug use is ‘unthinkable’ for them, they create a potential interactional dilemma for physicians who might otherwise be motivated to perform a more thorough history. In a sequential environment in which the patient has just portrayed him/herself as normatively appropriate, pursuing additional information (e.g., “Any drug use in the past?” or “Do you ever drink more than that amount?”) might be seen as insensitive to the patient’s depiction of his/her life circumstances. The physician might also risk being seen as skeptical that the patient is providing an accurate (i.e. truthful) portrayal of his/her conduct. Physicians may be reluctant to pursue additional information in this sequential position for fear of compromising rapport. Thus, patients’ enactment of ‘no problem’ stances is powerful not just in terms of self-presentation, but in terms of shaping the emergent interactional environment in a way that transforms the meaning of further inquiry by physicians.

In my corpus, there is one case that represents a departure from this ‘hands off’ approach by physicians, but it is important to note that it occurred in the context of a diagnostic history. As I note in the methodology chapter, it was not uncommon for patients to present acute problems during their routine medical checkups; this is both
expected and appropriate. In this case, the patient complained of insomnia and the physician followed up with a range of diagnostic queries. In line 1, the physician queried the patient about alcohol use at night, a possible explanation for his insomnia. The patient responded with an evaluative gloss ("Very little;"). Whereas this type of response was treated as utterly sufficient for the purposes of a routine substance use history, in this case of diagnostic history taking, the physician pursued the specific number ("Yeah° how much." in line 3).

R1106|2.03|"Alcohol Before Bed"

28. Doc:→ U:(b)m (0.5) alcohol at night?
29. Pat: .hhh (. ) Very little; [hhh] ((shakes head "No"))
31. Pat: Mmm=I may: have a beer once in a while er a glass
32. a wine once in a while;=
33. Doc: =Alright. ((writes in chart))

In lines 4-5, the patient provided the more specific information, though he also employed familiar features for implying unproblematic drinking (e.g. specifying beer and wine, using “once in a while” as an idiomatic gloss for infrequent use, using “I may: have” as a marker of epistemic distance). In line 6, the physician receipted this information with an intonationally affiliative “Alright” and made an entry in the patient’s chart. In doing so, he treated this more detailed version as the sort of response he needed in order to proceed. My main point here is that the physician sought to clarify the patient’s initial gloss, treating it as insufficient for the diagnostic purposes at hand. More data would be necessary to treat this as anything but speculative, but it may be that the presence of a diagnosable medical complaint provides physicians with a sense of license
in pressing patients to give them the information rather than just accepting their evaluation of it. Whereas their persistence might be viewed as skeptical in a routine history, in a diagnostic history it may be seen as dutiful and thorough.

(2) Research on Language and Social Interaction

This analysis was largely confirmatory of some broad themes I discussed in the literature review. Consistent with previous research on ‘delicate’ talk, patients used indirectness extensively in these histories. However, they appeared to be using indirectness somewhat differently. Whereas previous researchers have emphasized indirect or euphemistic formulations of sensitive terms (Silverman, 1994; Weijts, Houtkoop & Mullen, 1993), the indirectness I discovered seemed to be more about tucking their identity management activities into talk that was ostensibly designed for a different on-record purpose (information provision). This analysis also highlighted the myriad functions that can be incorporated into the activities of information exchange, even in a tightly structured institutional format. Previous research has tended to emphasize the multifunctionality of information seeking actions (e.g. Pomerantz, 1988) and this research complements that by emphasizing the multifunctionality of patients’ reporting actions. While still providing requested information, patients were able to tacitly display their own evaluation of that information and make a case for how the physician should understand it. They were able to project and restore character while still fulfilling their instrumental obligations to the history.

Given my focus on identity-in-interaction, or the interactional construction of identities, the most significant implications of this analysis for language and social interaction research center on Goffman’s conceptual framework.
An Empirical Application of Goffman’s Identity Concepts

One of the criticisms of Goffman’s approach to studying social organization is that he is unsystematic in his use of empirical evidence to support or exemplify his theoretical concepts (Leeds-Hurwitz, 2004). He is certainly eclectic in his choices of data, drawing liberally on ethnographic data, informal observations, commonsense illustrations, news clippings, fiction (books, films, etc.), etiquette manuals, and frankly anything else that might help a reader see how his theoretical account works at some more practical level. Goffman’s empirical eclecticism may be partly responsible for the corollary criticism that his theories are un-testable and thus not confirmable or disconfirmable. He provided little guidance on how one might operationalize or measure his concepts in action. Ultimately, I do not see this analysis as testing or confirming anything about Goffman’s theoretical perspectives, but I would argue that they do provide an analytically rich set of tools for making sense of patients’ activities during lifestyle history taking. I view this project as an empirical application of his theoretical lens, one that speaks to its usefulness, if not its accuracy or ‘truth.’ I would also argue that this systematic analysis of one focused empirical circumstance (lifestyle history taking) suggests some ways to expand or enrich his concepts.

Situated identity and character.

Goffman’s notions of situated identity and character provide a compelling explanation for the ‘special’ interactional work in which these patients were engaged. The concept of situated identity invites us to appreciate how social actors work to claim roles and visibly fulfill the obligations of role incumbency, which in this case meant doing the things that were expected of physicians and patients during a routine history.
This appeared to be an overarching concern for the participants; at virtually all points, they maintained an on-record orientation to their roles in accomplishing this activity. Knowledge of the patient role appeared to operate as a constraint on the interational resources and space/time that were available for addressing character. The character-implicative practices I describe were woven into activities that were otherwise situationally appropriate (i.e. answering questions by reporting information).

The concept of character invites us to appreciate how social actors work to display culturally desirable qualities or to resist culturally problematic ones. It provides a way to talk about those social moments in which something fundamental and enduring about one’s self is thought to be revealed (what Goffman calls “character contests”). Goffman conceptualizes character in terms of the trans-situational moral evaluations we make about behavior, above and beyond the local requirements of any particular situated identity. While I cannot claim with any certainty that patients were motivated by concerns about character, their interactional behavior certainly suggests that they were concerned with something more than providing appropriate medical information. Character provides a way to talk about the social concerns patients appeared to be bringing into the medical setting.

In this analysis, I proposed that ‘health consciousness’ could be understood as an aspect of character. I framed health consciousness in terms of a moral obligation to take care of oneself, or at least avoid self-destruction. Goffman did not discuss health consciousness at all. The primary qualities he associated with character were: courage, the ability to proceed in the face of danger; gameness, the ability to persevere despite setbacks; integrity (self-respect and self-discipline), the ability to resist temptation;
gallantry, the ability to maintain forms of courtesy in difficult circumstances; composure, the ability to maintain poise under pressure. My reading is that Goffman did not intend this to be an exhaustive list, just one that reflected a range of attributes that are understood to implicate something essential (or characteristic) about a person.

In my view, health consciousness fits well into this framework. It overlaps in some ways with the notions of self-respect and self-discipline, the ability to behave responsibly in service of one’s own dignity or preservation. It also embodies a moral orientation toward ‘good’ and ‘bad’ courses of action. Conrad (1994) argues that in the last 20 years there has been an explosion not just in health promotion and fitness initiatives, but in the moral terms with which action or inaction in these domains is understood. Saguy and Riley (2005) show that current debates over obesity, another lifestyle-related health issue, are often framed in moral terms, where obesity is regarded as a matter of moral culpability. Like other aspects of character, health consciousness can also be seen as a trans-situational aspect of identity. Although displays of health consciousness may be especially relevant for certain situated identities or roles (e.g. physician, patient, fitness instructor, surgeon general), it may also serve as a basis on which to evaluate persons regardless of the particular situated identities they are enacting. For example, whether one is enacting the role of sister, co-worker, professor, or president, being seen smoking a cigarette may engender evaluations about that person’s strength of character, their commitment to their own self-preservation.

19 In a recent article by Zeleny (2009) in the New York Times, President Obama’s cigarette smoking is described in strongly evaluative terms. Obama’s own quotes speak to a sense of shame: “‘I don’t do it in front of my kids,’ he said. ‘I don’t do it in front of my family. I would say that I am 95 percent cured, but there are times where I mess up.’” Other quotes reinforce the problematicity of incumbency in the identity category of
In the limitations section of this chapter, I address some concerns I have with my use of the concept of character.

**Splitting the self: a robust conceptual metaphor for understanding remediation.**

Goffman presented the notion of ‘splitting the self’ as a way to understand apologies, though he also noted that this kind of work may be evident in other forms of remediation. This has been a very useful concept in this analysis, particularly in analytic chapter two, where patients were apparently motivated to account for lapses in health consciousness and/or moral propriety. Many instances of the character-restoring practices I discussed seemed to trade in one way or another on the splitting of the self into a blameworthy component and a virtuous component.

When patients displayed independent awareness that their reported lifestyle conduct was potentially problematic, they split the self into a component who has behaved badly and a component who knows better. When patients mitigated personal agency in their conduct, they split the self into a component who was led astray by outside influences and a component who would never do those things on his/her own. When patients framed problematic conduct as ‘in my past’ or already resolved, they split the self into a component who made mistakes and a component who has already set them right.

These practices lend further support to the conceptual value of this concept, but they also represent a novel application of it. In the traditional model of a remedial

‘smoker’ and further demonstrate the kinds of character-enhancing definitional parsing that people may do when they talk about their smoking: “‘Have I fallen off the wagon sometimes? Yes,’ Mr. Obama said Tuesday at a White House news conference. ‘Am I a daily smoker, a constant smoker? No.’”
exchange between two or more social actors (Cupach, 1994), an offense committed by social actor A is followed by a reproach (or criticism) by social actor B, which sets up remediation as a relevant next action for social actor A. In this model, splitting the self is a form of remediation designed to address a grievance. In this analysis, I have shown that splitting the self is not just a reactive strategy employed in the face of a reproach; it can be a proactive strategy employed for the purposes of projecting a desirable identity when that may be in doubt.

An information management dilemma for patients.

In *Stigma: Notes on the management of spoiled identity* (1963), Goffman discusses the critical link between one’s biography -- essentially information about one’s past experiences and activities -- and one’s identity. Although he developed these ideas to describe the identity management projects of socially stigmatized persons such as criminals or ex-mental patients, they are also useful for understanding patients’ activities during routine lifestyle history taking. When biographical information has the potential to discredit or ‘spoil’ one’s identity, interaction with others requires careful management of personal information. Individuals with potentially discrediting biographies tend to be cautious and selective in who gets to know what. An individual may have an inner sanctum of others who know everything (such as family members), but people in more periphery layers of intimacy may have access only to fragments of information, distortions, or outright misrepresentations. In some, but not all, social situations, persons with discrediting information have the option of hiding that information and this is an important resource for minimizing stigmatization.
For patients who have potentially problematic lifestyle conduct to report, information management is arguably more complex and dilemmatic (though the stakes are probably lower than those of a criminal). On one hand, openly disclosing discrediting information has the potential to spoil their identities. On the other hand, withholding or distorting discrediting information has the potential to diminish the quality of care they receive. If, for example, a patient is unwilling to risk the identity inferences that might result from disclosing past intravenous drug use, his/her physician likely would not test for hepatitis. The dilemma is whether to prioritize one’s health or one’s moral standing. This is, I think, well understood by medical practitioners and may account for why training materials emphasize the importance of creating a non-judgmental tone. If physicians can ameliorate concerns about judgment, the dilemma is essentially resolved for the patient; quality of care becomes the guiding priority.

Most medical education initiatives target the physician, focusing on what s/he can do to promote trust and openness in these domains. Patients are largely framed as passive participants who can only hope that their physician gets it right. However, the interactional practices for restoring character that I described in analytic chapter two can be understood as patients’ solutions to this dilemma. By asserting some interactional initiative, patients were able to provide medically useful information while also subtly resisting the discrediting inferences that might be drawn from it. Whereas Goffman’s initial conceptualization of information management emphasized the kinds of ‘fronts’ and outright deceptions required to pass as normal, this analysis emphasizes the subtly rhetorical ways in which patients packaged their information to balance multiple concerns.
Limitations

The Definitional ‘Looseness’ of Character

It is fair to say that the concept of character carried a lot of water in this project, perhaps more than Goffman would have intended. I used character in a relatively inclusive way to talk about various trans-situational, morally inflected aspects of personal identity that were not functionally tied to the situated patient role. The concept of character was already fairly broad, encompassing diverse qualities like courage, integrity, composure, and gameness; I further broadened it by including health consciousness as a component. In the end, character functioned as an overarching gloss for a collection of loosely related personal attributes. I was left wondering what kinds of personal qualities couldn’t be seen as somehow character-implicative, in which case character simply becomes a catch-all for any apparent identity work that isn’t clearly associated with the relevant situated, transportable, or discourse identities in that social moment.

I relied on character because it provided some kind of established conceptual vocabulary for talking about the things I saw patients doing, things that, at least on the face of it, didn’t seem especially relevant to seeking medical care. Why would a sexually inactive patient indicate that, “there is hope” for her? Why would patients bother indicating that they drink beer (not liquor) or that they drink with colleagues or that they drink on weekends? Why would patients become righteously insistent that they don’t use drugs just moments after a simple ‘no’ was enough to indicate that they don’t smoke cigarettes? Character provided an identity-based concept for talking about what might be at stake for these patients: the moral quality of the person -- the performer -- behind the patient role.
This may partly explain some of the definitional looseness I am attributing to character (or at least my use of it). Most interactional perspectives on identity tend to be focused on the social or interactional qualities associated with specific role categories, not the personal qualities of the actor behind them. One advantage of approaching identity in terms of role categories is that we can draw on accessible cultural labels. I think this helps with the coherence of situated, transportable, and discourse identities. When we talk about situated identity, we can use labels like physician, patient, jogger, or artist. When we talk about transportable identity, we can use labels like woman or Asian. When we talk about discourse identity, we can use labels like storyteller or teaser. Because these categories of persons are associated culturally with specific category-bound features, we can look for these features in interaction and make claims about the achieved relevance of the categories.

Character does not seem to work this way. Goffman talks about ‘strong’ or ‘weak’ character, but these do not resonate for me as categories of persons, at least not in the ways that stepmother, African American, or information seeker do. So the question becomes, how can we talk about these fundamental, trans-situational aspects of personal identity that are not reducible to the local relevance of categories, types, and roles? At this point, it is not clear what the answer is, but character provides at least some analytic traction.

Methodological Issues

Limited Generalizability

For various reasons, these findings cannot be generalized to other medical settings or populations. First, the selection of participants involved a combination of purposive
and convenience sampling, not random sampling. The physicians essentially self-selected to participate by responding to an email solicitation. Not every patient at the practice was a candidate for inclusion in the study; only patients of participating physicians were considered. Moreover, only those patients who had scheduled appointments on data collection days were solicited. Second, it is possible that the sample of physicians and patients was biased toward those who were comfortable being video recorded. The participation rate among patients was 44% and the remaining 56% might have declined to participate in part because of the recording. I do not have data on how many physicians received the email solicitation, but it is possible that some declined because of the video recording. My liaison at the family practice, a non-physician faculty member in the department of family medicine, told me informally on several occasions that many physicians there “hate” being recorded, even for teaching and quality assurance reasons. At the same time, even those who consented to be video recorded may have altered their conduct because of discomfort or because of social desirability concerns. This reduces the naturalism of the interaction, which reduces validity and ultimately the generalizability of findings. Third, two of the six physicians (Dr. A and Dr. R) were markedly overrepresented in the data set. Of the 24 consultations recorded for the study, these two physicians accounted for 16 cases. Two other physicians (Dr. M and Dr. P) were markedly underrepresented, accounting for one consultation each. While my claims are primarily about patients’ conduct, it is possible that the overrepresented physicians’ style influenced what their patients did.
Attribution of Motives

As I noted in the introduction of analytic chapter one, I have departed in some ways from conversation analytic orthodoxy by attributing motives to patients’ activities. Specifically, I operated under the assumption that they were motivated to enact strong character or to restore character. There are two potential problems with this approach.

First, because I relied exclusively on interactional data, I am quite limited in my ability to substantiate claims about speakers’ intentions. I can only make inferences based on my access to the same shared cultural knowledge that patients were apparently invoking for their physician recipients. Had I chosen to complement the interactional data with survey or interview data, I would be in a better position to claim that concerns about identity shaped participants’ conduct.

Second, most of the practices I described were indirect or implicit, which further erodes the confidence with which an analyst might attribute motives to talk. Indirectness has been described as a resource for doing social business without being held accountable for having done it (Brown & Levinson, 1987). The very practices that keep such business off-record for the participants also make it difficult for an analyst to convincingly attribute motives.

Directions for Future Research

Physicians’ Interventions Into Patient Lifestyle

This analysis has focused exclusively on seeking and reporting information about patient lifestyle. Gathering information is certainly an important part of providing medical care, but physicians also have a role-based obligation to intervene when patients present with possible health issues. Future research should examine how physicians
handle this in these potentially sensitive domains. Previous research has shown that the most common form of intervention into lifestyle is advising behavioral changes, such as reduction or cessation of smoking, drinking, or drug use (Pilnick & Coleman, 2006; Roche & Richard, 1991) or more consistent use of condoms (Silverman, 1997). An exploratory investigation of my own data shows that another form of intervention into lifestyle is advising patients to be tested for STIs, though I have found no research that investigates primary care physicians’ methods for doing this.

Drawing on this analysis, it would be worth investigating whether or not physicians formulate their advice and other interventions in ways that are sensitive to possible identity concerns (and, if so, how they do). Previous research on advice in both medical and non-medical contexts suggests that identity concerns can play a role in advising activities (Goldsmith, 2000; Heritage & Sefi, 1992; Pudlinski, 1998; 2002; Silverman, 1997; Vehvilainen, 2001; Waring, 2005, 2007). Many concerns emanate from the proposition that advising involves asymmetrical role enactments, where the advice giver is “one up” (Tannen, 1994) on the advice recipient. Advice can be identity threatening for what it implies about the relative knowledge, expertise, or influence of the participants. Advice givers may be concerned to enact the identity of ‘caring supporter’ and not ‘intrusive know-it-all.’ Advice recipients may experience advice as indirect criticism or as a threat to their autonomy and competence. Their acceptance or rejection of the advice can also have identity implications for the advice giver. When a person accepts advice, they tacitly ratify the advice giver’s claim to legitimate situational expertise. When a person resists or rejects advice, this may be called into question.
Goldsmith and Fitch (1997) note that these identity concerns are also informed by the other roles, identities, and statuses that bear on the interaction. Much of the research in this area examines advice in institutional contexts (Heritage & Sefi, 1992; Pudlinski, 1998; 2002; Silverman, 1997; Vehvilainen, 2001; Waring, 2005, 2007) and shows how institutional identities become relevant to the interaction. For example, Pudlinski (1998; 2002) analyzes advice-giving episodes on consumer-run ‘warm lines.’ This is essentially a telephone-based peer-to-peer mental health support service. As part of the institution’s commitment to individual agency and empowerment, call takers were trained not to offer advice to callers. While they did sometimes offer advice, they did so in ways that were subtle and implicit, sensitive to the constraints of their institutional roles. At other times, call takers made reference to their own struggles with mental health, invoking their co-membership in this identity category. This allowed them to use empathic personal stories of problems and solutions as a resource for tacitly advising courses of action. Given that physicians are understood to have a role-based expertise to offer medical recommendations, one wonders if they would downplay their own authority in the ways that other institutional professionals do.

**Developing Physician Training Materials**

The findings of this analysis could be developed further for use in physician training materials, although I don’t think that this should be delivered as didactic, ‘do-this-don’t-do-that’ messages. Rather, I think physicians could benefit from understanding some basic issues and challenges in order to develop approaches that work within their own personal style and their understanding of their patient population.
One issue that physicians might consider is how to perform a thorough history when patients initially work to present their lifestyle conduct as normal, unproblematic, or desirable. As I noted, being persistent in that environment could risk appearing insensitive to the patient’s portrayal of his/her circumstances or could seem untrusting. One solution to this might be to acknowledge that the patient’s baseline of activity is normal and unproblematic, but ask if there have been exceptions. Patients may be more willing to discuss past or current issues if they have already been positioned as exceptions to the norm. Another solution would be to begin the substance use history and the sexual history with a standardized disclaimer that they ask all patients all of the proceeding questions regardless of what they answer. They might further attribute this to institutional mandate, framing the thorough history as something they have to do. These depersonalizing moves could resist the appearance that the physician’s questions were motivated in some way by what the patient had reported. They also provide a warrant for asking a series of questions, regardless of the answers.

Another issue that physicians might consider is whether or not they can actually leave social morality out of the encounter. Physician training materials are replete with advice about avoiding the appearance of moral judgment and this is probably good advice. In my own informal conversations with physicians, they frequently insist that the best way to ask patients about lifestyle is to treat it as no different from any other aspect of health. One physician suggested (I think only half-jokingly) that, “you should ask about their penis the same way you’d ask about their elbow.” Their rationale is essentially that this can serve to desensitize potentially sensitive matters. While this is probably good practice in many respects, my data suggest that patients themselves can
introduce the relevance of social morality in the encounter. How should physicians respond when patients are the ones doing the judgment? Should they confirm patients’ assessments of their conduct? Should they challenge the implicit moral precepts that undergird the assessment?

I briefly revisit one of the cases in my collection (Case 1 from analytic chapter two) to point out what I see as one elegant solution by a physician. In this case, the patient had indicated some regret about having too many sexual partners. He formulated this with the tag question, “right,” essentially inviting the physician to confirm that this was regrettable. In response, the physician asserted a medical basis on which such an evaluation should be made, tacitly positioning moral concerns about promiscuity as not relevant to the encounter.

R1025|8.00|"HIV Test Hard Sell"

11. Doc:  How many _lifetime_ sexual partners do you have.
12. Pat:  .h (0.5) U:mhh u::h that’s a big one huh, HEH HEH
13.      [.hh]
15.      (0.2)
16. Pat:  I’ll say close to- close to: fifteen to
17.      twenty.=hh heh
18. Doc:  Wh[at ] percent uh the ti[me]
19. Pat:   [( )]                  [ I] prob’ly regret that
20.      now right,=hhhh[h]
22.  ⇒ condoms?
23. Pat: M- fer the most part.= 
24. Doc: =Okay

In lines 11-12, the physician withheld his response to the patient’s “right,” instead making his own assessment contingent on whether or not the patient used condoms (“[W]e'll d- I mean didja’ use condoms?”). By making the regrettablility of the patient’s conduct contingent on condom use, the physician tacitly proposed a medical basis for evaluation. He implied that, as long as the patient used condoms, there was no medical basis for regret. Interestingly, I suspect that the physician was on his way to asking about condom use in line 8 (“[W]hat percent uh the ti[me]”), but abandoned the turn when the patient started his regret utterance. If so, this was especially resourceful of the physician, as he was able to sidestep the question of morality while also continuing to advance his information-seeking agenda.

Ultimately the point here is not to equip physicians with these specific interactional methods, but rather to encourage physicians to consider ways that they can handle the emergence of moral concerns during the encounter.

Summary

Patients engaged in some special interactional work when they reported on their lifestyle conduct. In providing marked and/or elaborated responses to physicians’ queries, they departed from the minimal response formats associated with routine history taking. I argue that this special interactional work was designed in part to accomplish two different identity management projects. These projects displayed an orientation to broadly shared cultural understandings about the inference-rich character of lifestyle behaviors. In various ways, patients worked to have their activities and perspectives understood in normatively, morally, and medically desirable ways. Patients expressed their agency in
these environments, working to influence how their information should be understood by their physicians. However, they accomplished this in ways that were sensitive to the institutional setting and their situated role in the activity as reporters of information. Specifically, they employed a range of interactional practices that accomplished identity work in an implicit or indirect manner. Although physicians were generally uninvolved in patients’ identity management projects, I offered some tentative arguments about how their conduct was subtly supportive of patients’ identity work.
References


Interaction between Primary Care Physicians and Patients (pp. 115-150). Cambridge: Cambridge University Press.


